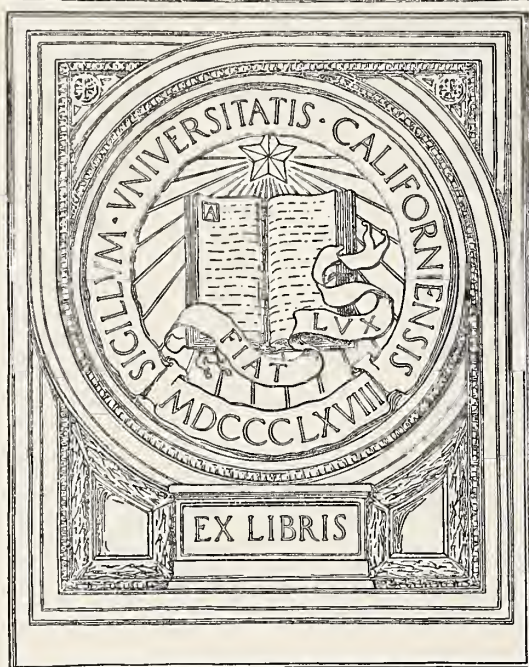
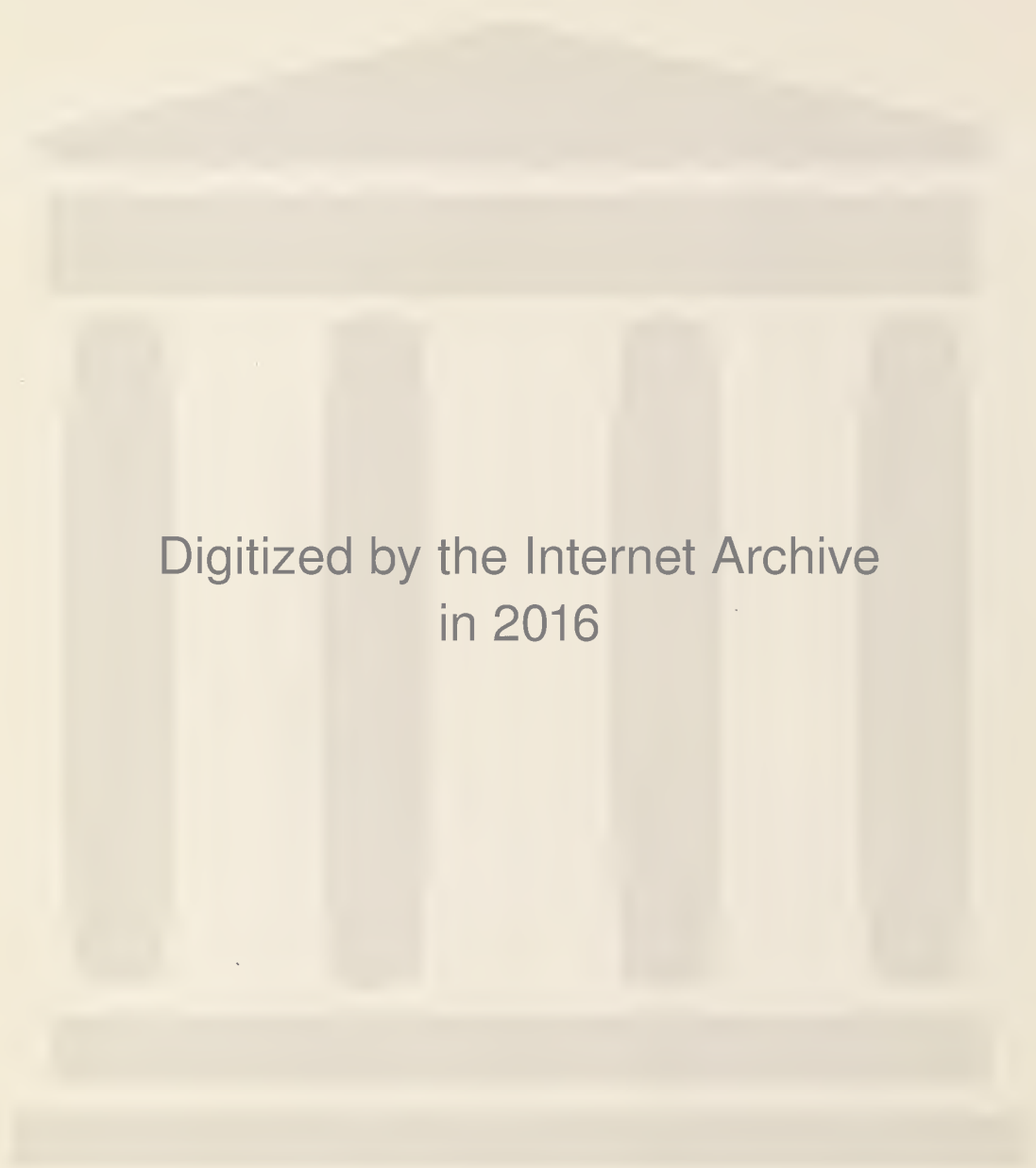


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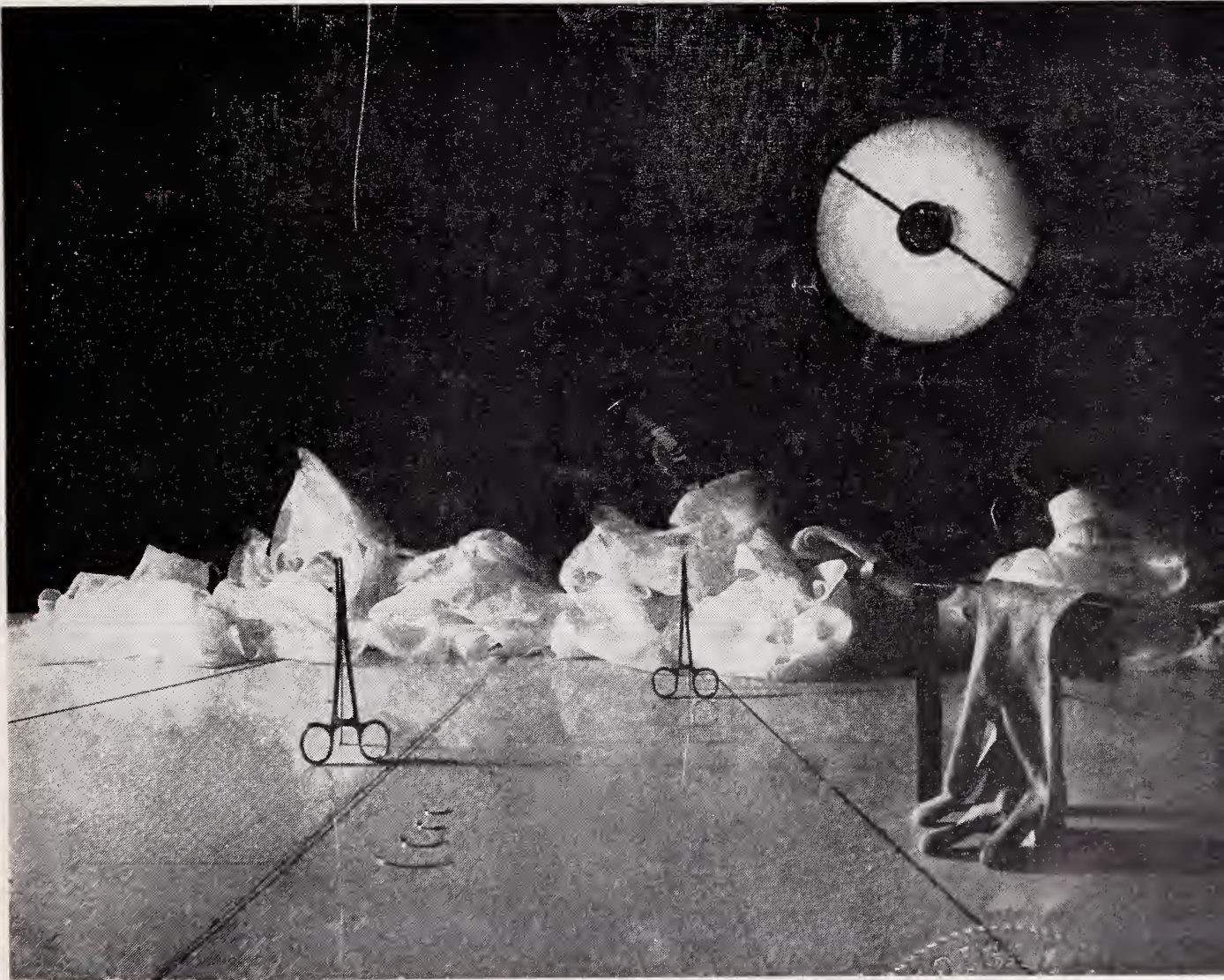
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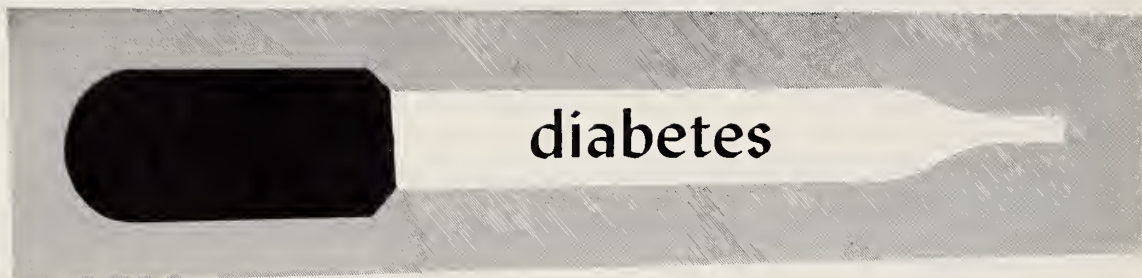




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1. Blotner, H., and Marble, A.: *New England J. Med.* 245:567 (Oct. 11) 1951.

2. Steine, L.: *GP* 8:45 (July) 1953.

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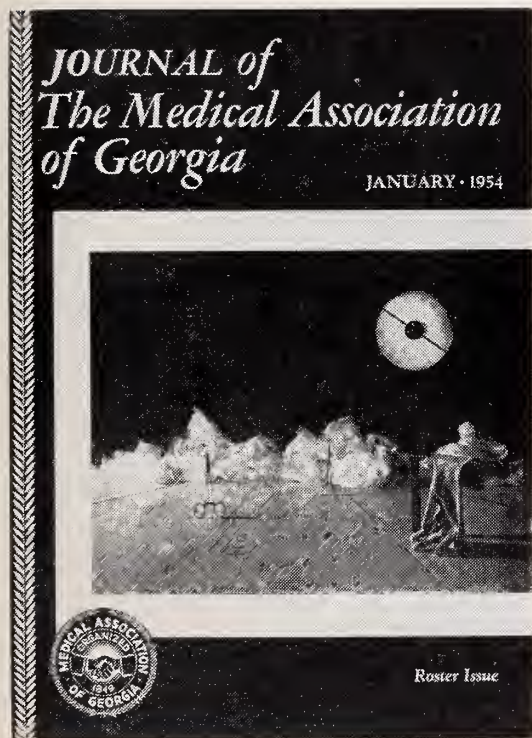
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The JOURNAL
of the
MEDICAL
ASSOCIATION
OF GEORGIA

JANUARY, 1954

VOLUME 43

NUMBER 1



The surrealistic surgical landscape on our cover is the creation of Ted F. Leigh, M.D., photographic editor of the JOURNAL. Spread out under the "moonlight" of a surgical lamp are silk sutures, clamps, retractor, glove and "mountains" of gauze. This abstract photograph marks another first for the JOURNAL, which customarily carries a realistic photograph on its cover.

JANUARY, 1954

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MANUSCRIPTS

Articles are accepted for publication on the condition that they are contributed solely to this *Journal*. Manuscripts should be typewritten, double-spaced and the original, not the carbon copy, should be submitted. Receipt of manuscripts will be acknowledged and unused manuscripts returned. Used manuscripts will be returned only if requested.

STYLE

Ordinarily articles should not exceed 3,000 words. Only under exceptional circumstances will articles of over 4,000 words be published. Footnotes, bibliographies and legends should be typed on separate sheets, double-spaced. Bibliographies should conform to the style of the Quarterly Cumulative Index published by the American Medical Association—i.e., name of author, title of article, name of periodicals with volume, page, month, day of month if weekly and the year. They should be listed in alphabetical order and numbered in sequence. Example: Jones, S.R.: Spontaneous Epistaxis, Arch. Int. Med., 36:434 (Dec.) 1946.

NEWS NOTES

District and County Medical Societies, Association members and readers are invited to send in any news items of general concern to members of the Medical Association of Georgia.

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Requests for reprints should be made direct to Mr. T. D. Thompson, Franklin Printing & Mfg. Co., 675 Drewry Street, N.E., Atlanta, Georgia. Reprints must be ordered within 30 days after publication, since all type will be destroyed after that time.

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The Editor and members of The *Journal* Editorial Board will permit authors to have as wide a latitude as the general policy of the *Journal* and the demands on its space permit. The right to reduce, revise, or reject any material submitted for publication is always reserved. The *Journal* is not responsible for statements made by any contributor. All communications regarding editorial, advertising, subscription and miscellaneous matters should be sent The Editor, 875 West Peachtree Street, N.E., Atlanta, Georgia.

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If in the opinion of the *Journal* Editorial Board, material submitted for publication could be improved by a Medical Editing Service, the Editor will contact the author for his approval. Association members needing assistance in preparation of material for publication may also use this service. A reasonable charge is made for this service and the cost of this will be borne by the author.

ADVERTISING

All advertising copy approved by the Councils of the American Medical Association shall be acceptable for publication. Other advertising copy may be accepted subject to the approval of the Editor and members of the Editorial Board. All copy or plates must reach the *Journal* office by 10th of the month preceding publication. General and classified advertising rates will be furnished on request.

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REFERENCES

1. Cathie, I.A.B., and MacFarlane, J.C.W.: Brit. M. J. 1:805 (April 11) 1953.

2. Coriell, L.L., and others: Antibiotics & Chemotherapy 3:357 (April) 1953.

3. Barach, A.L.: Geriatrics 8:423 (August) 1953

4. Finberg, L., Leventer, I., and Tramer, A.: Antibiotics & Chemotherapy 3:353 (April) 1953

5. Editorial: Antibiotics & Chemotherapy 3:347 (April) 1953.



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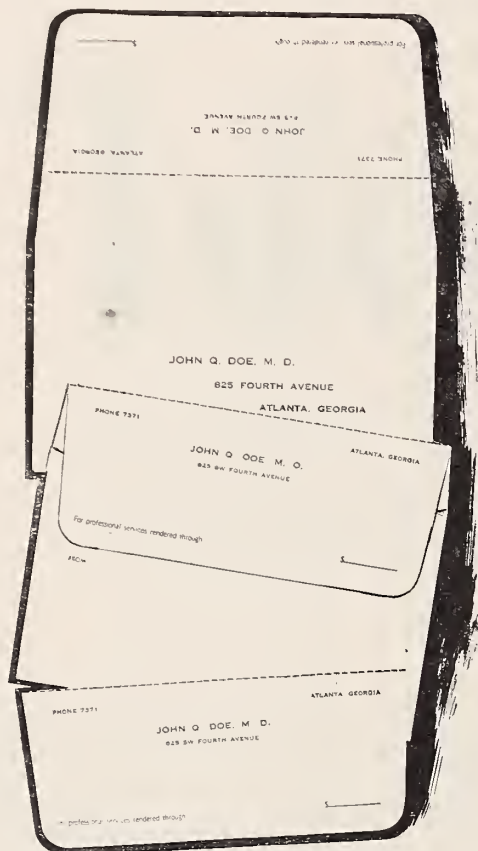
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1. Kauntze, R., and Trounce, J.: Treatment of Arterial Hypertension with Veriloid (Veratrum Viride), *Lancet* 2:1002 (Dec. 1) 1951.

2. Wilkins, R. W.: Combination of Drugs in the Treatment of Essential Hypertension, *Mississippi Doctor* 30:359 (Apr.) 1953.

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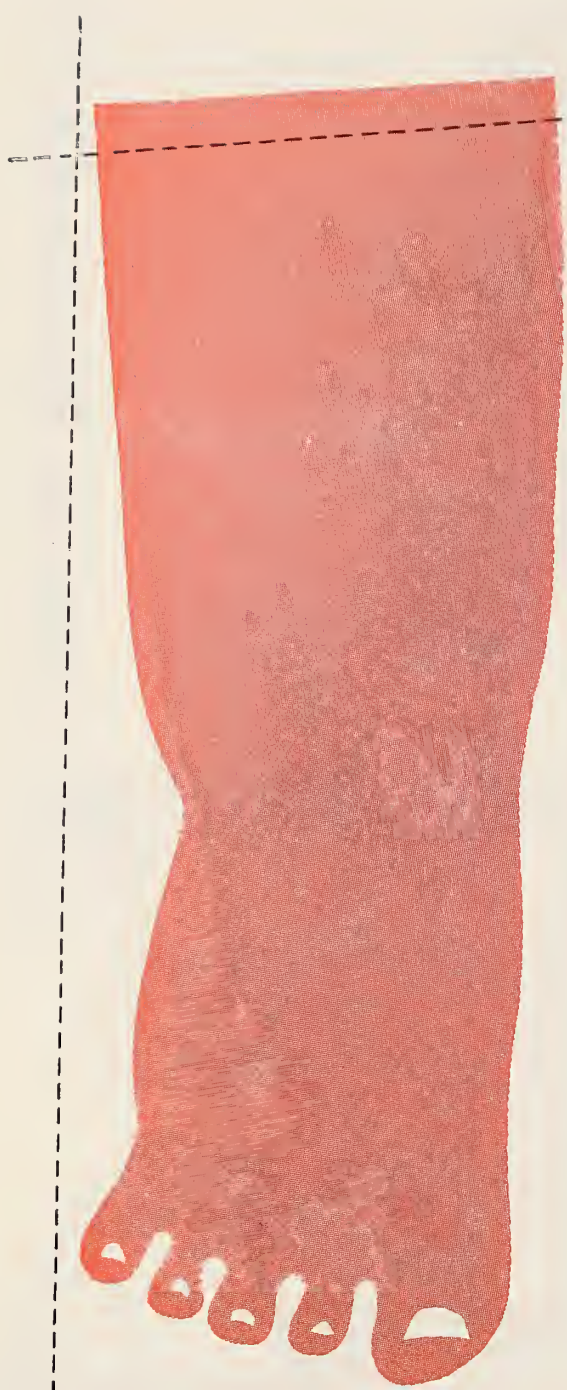
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editor's mail

To the Editor:

Due to the fine cooperation of the Executive Office of The Medical Association of Georgia, the Better Health Council held a most successful meeting in Athens, December 1. As you can see by the enclosed program, the physicians were well represented, first, by Dr. Peter B. Wright who opened our meeting with some pertinent facts on health problems in Georgia today. Dr. John Simpson from Athens made a fine contribution to school health and gave many excellent suggestions as to improvement in the program. Dr. George Nicholson was factual in his presentation of health insurance and brought out many points that the lay people were interested in when buying policies on health insurance. Dr. W. W. Turner was the "hit" of the day from many standpoints especially from the extension division of the University of Georgia, Agricultural Service. One community leader said that the meeting was worth attending if she had only heard Dr. Turner's paper. The physicians who acted as consultants were pungent in their remarks and the simple presentation from all was most gratifying.

Thank you for assisting us in making this meeting so successful and we look forward in the future to that same kind of relationship with the Medical Association and its members.

Sincerely,

ANNA LAURA REID
Executive Secretary
Better Health Council of Georgia

To the Editor:

My associates and I are engaged in a study of blood pressure in people 65 and over, sponsored by the New York Heart Association. Three weeks ago we mailed questionnaires to 17,000 physicians throughout the country. Each physician received a letter of instruction in filling out the questionnaires. It was suggested that he supply blood pressure and other data on six cases, if possible. Thus far the number of responses has been disappointingly small. Although we realize that a relatively short time has elapsed since the questionnaires were sent out, we are afraid that many physicians may not appreciate the value of this study and the fact that it must fail unless they give full cooperation.

In order to bring these facts to the attention of the medical profession, we would appreciate it if you could find space in your journal to present the project, either editorially or in a special announcement, and to urge the support of physicians.

With sincere thanks for your cooperation.

Sincerely,

ARTHUR M. MASTER, M.D.
Director New York Heart
Association, Inc.

To the Editor:

It is regrettable that during my short stay in Atlanta I had the privilege of only one short glimpse of you and that I never found time to get by the Georgia State Journal office.

The cover on your November Journal with "Doctor Carver" standing ready for action indicates that you are ready to "talk turkey."

Mary Lou, my editorial assistant, tells me that your Journal had favorable mention at the State Journal Conference in Chicago. I had just barely gotten back from Georgia and Virginia and could not attend.

With good wishes for your continued success I am,

Sincerely,

LEWIS J. MOORMAN, M.D.

Editor-in-Chief

Journal of The Oklahoma State
Medical Association

To the Editor:

I feel as though the memory of Dr. Thomas Callahan Davison, also known to many friends as Callahan or T. C.—never as Thomas, was not clear when alluded to as Thomas. If I had not known of his death I probably would have passed over Thomas C. and never realized who it was.

I think of the years he gave of his time and self as an unpaid teacher at the old Atlanta College of Physicians and Surgeons and later to its successors, the Atlanta Medical College and the present Emory.

He was friend, counselor and father to many poor, discouraged medical students, and I am sure that he was the same person in his practice to the poor, sick and needy. A spiritual and human helper, he gave hours of his life not only to the various clinics but to the individual patient. The welfare of his patient came before the welfare of Callahan.

I could go on and on mentioning his many virtues, his good as a teacher and leader in medicine and surgery, the many calls to practically every County Medical Society in the state, as well as in many other states, to read and discuss papers, thereby giving other doctors the benefit of his knowledge. This was always done in a modest, unassuming way, though positive and forceful to impress you in his confidence of what he was saying. Though a leader and a teacher, he was always ready to listen and learn.

Dr. Thomas Callahan Davison—a Christian and ardent, active church worker, a teacher and worker in the art and science of medicine and surgery, a kind and generous person to his fellow man, a loving husband and father, a home maker, setting a fine, high and noble example to all he came in contact with, an unselfish man who dedicated his life to aid the poor, sick and suffering humanity.

Sincerely,

H. M. MOORE, M.D.
Thomasville

hospital page



Tri-County Hospital Fort Oglethorpe, Georgia

Three counties in North Georgia have united to form the Tri-County Hospital Authority. These counties are Walker, Dade and Catoosa. The Tri-County Hospital was developed on the site of the old station hospital at Fort Oglethorpe, Georgia. The

Tri-County Hospital has one hundred and ten beds. This hospital was opened to serve the people of that area in November, 1953. Fort Oglethorpe is well known to many physicians who served as medical officers in the U. S. Army during World War I. Fort Oglethorpe was at that time a training center for newly appointed medical officers.



Pierce County Hospital Blackshear, Georgia

The Pierce County Hospital at Blackshear, Georgia

with a capacity of twenty-five beds opened for the reception of patients during September, 1953. This hospital serves Pierce County and adjoining areas. This is the first hospital to be built in Pierce County.

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Meat...

and Its Place in the Diet in Hypertension

Contrary to the concept that protein intake contributes to the genesis of hypertension and should be drastically reduced in therapy^{1, 2, 3} adequate protein nutrition today is considered essential for preserving maximal vigor and a sense of well-being in the hypertensive patient.³ Meat, once thought to be contraindicated, now is recognized as an important protein food in the dietary regimen in hypertension.

High-protein foods do not elevate arterial tension — neither in the hypertensive nor the normotensive person. Nor does the specific dynamic action of protein make undue demands on the heart.^{2, 3, 4} Only in advanced hypertension when renal function is seriously impaired, or in cardiac emergency episodes, when cardiac disease complicates hypertension, is restriction of protein intake below the normal allowance of 60 to 70 Gm. per day justifiable.^{2, 3}

But not only for its high content of biologically top-quality protein is meat a recommended daily food in the diet of the hypertensive patient. It also goes far toward satisfying the needs for essential B vitamins and minerals. Another important feature of meat is its outstanding taste appeal and its virtually complete digestibility.

-
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 4. Levine, V. E.: The Blood Pressure of the Eskimo, *Federation Proc.* 1:121 (Mar. 16) 1942.

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the executive secretary's letter

Your 1954 Dues

MAG House of Delegates (at the 1953 Annual Session) changed the Association fiscal year to January 1 through December 31 to facilitate bookkeeping. This means that Association members' 1954 dues were to be collected by the County Medical Society and forwarded to the MAG Headquarters office no later than January 1, 1954. And in succeeding years, dues must be paid before January 1 of the year they are to cover.

During this year of transition, from the old to the new, the rules for considering a member delinquent are given in the Constitution and By-Laws as follows: "... They shall be payable on or before January 1st of the year for which they are levied ... Any member whose name has not been reported for enrollment and whose dues for the current year have not been remitted to the Secretary-Treasurer of the Association on or before April 1st, shall stand suspended ..."

If a member's dues for 1954 have not been forwarded by the County Medical Society to the Headquarters office by April 1, 1954, that member will be considered *delinquent* and shall not be entitled to the privileges of membership including Medical Defense.

Polio Vaccine

A recent meeting sponsored by the National Foundation for Infantile Paralysis was held in Atlanta with representatives from the State Board of Health, the State Board of Education and the MAG. Discussion centered on the field trial of the Salk polio vaccine in Georgia. Under consideration for the vaccine field trial are Georgia areas where the polio incidence was high.

Vet's Affairs

As reported in the Association *Journal*, two conferences on Veterans Medical Care have been held recently. The first meeting, a Southeastern Regional Conference was sponsored by the AMA. A second meeting was called by the MAG Veterans' Affairs committee to discuss information gained from the regional conference.

The discussion at these meetings concerned AMA and MAG policy on non-service-connected disabilities treated under the present law by the VA. Ways and means of implementing AMA policy were discussed and plans were formulated to bring this discussion to your District and County Society meetings.

Certain MAG members have been asked to introduce this subject at your January and February sessions. Look for these talks at your next meeting.

Georgia Plan

In an effort to make the present Georgia Plan of prepaid medical insurance more feasible to the physician, the patient and the insurance company, the MAG Insurance Board is considering some practical revisions. Matters under consideration include: a better explanation of the plan to prospective insurees; a revision of the schedule of fees; aggregate family income for maximum income limits; increased medical coverage, etc. Also contemplated is a drive to increase MAG physician participation in the Georgia Plan.

Doctor Placement

The Headquarters office is in the process of completing an up-to-date file of "locations seeking physicians" and "physicians seeking locations." Locations have been sent detailed questionnaires. These will provide data for the physician seeking to practice or relocate in Georgia. This file with all data will be completed by the end of January and both the names of physicians and locations will be published monthly in the *Journal*. Full data from the files can then be obtained upon request from the Headquarters office.

Emory Grant

Reliable medical sources state that a sizeable capital grant has been made to the Emory University School of Medicine by a foundation. It is understood that the grant is in two parts, namely, one for endowment and one toward a building. These sources were quick to point out that the additional fund will not actually mean any *new* income for Emory Medical School, but will place on a permanent basis annual gifts which have been made by the donor for some years.

'54 Annual Session

Plans for the MAG 1954 Annual Session are almost completed. The scientific program has been tentatively arranged with the sections meeting each morning followed by panels. The guest speakers will discuss topics chosen by the section sponsoring the panel.

The specialty societies, allied medical groups and member physicians have been encouraged to present

executive secretary's letter (cont.)

scientific exhibits. A fair response has been received to date. Technical exhibitors have been invited and the response has already exceeded last year's total.

An important reminder to each physician: Make Your Hotel Reservations Now for the 1954 Annual Session, May 2-5, Macon. For Reservations Write: Dr. Leon D. Porch, Chairman, Hotel Reservations, Medical Association of Georgia, P.O. Box 288, Macon, Georgia.

Better Health Council

After a successful Northeast Regional Health conference in Athens which was devoted to the general topic of "School Child Health," more conferences are slated for '54. Sites for meetings include Swainsboro (East Central), Albany (Southwest), Waycross (Southeast) and Thomaston (West Central). These conferences are endorsed by your Association and participation of physicians for counsel and guidance is a "must" function of the MAG membership. Physicians are urged to attend these conferences when notified through their County Medical Society.

Atlanta Graduate Assembly

Scheduled for February 22, 23 and 24 at the Biltmore Hotel, Atlanta, is the annual Atlanta Graduate Medical Assembly. Highlights of the program include symposiums on Isotopes, Gastro-enterology, Cardiology and O.B.-Gyn. Many distinguished guest speakers are on the program. For registration details write: Atlanta Graduate Medical Assembly; Attn.: Mrs. S. R. Roberts; 15 Peachtree Place, N.W.; Atlanta, Georgia.

MAG Committees

The backbone of the MAG is its committee system which follows the instructions of the House of Delegates in implementing and carrying out MAG policy. The Association only accomplishes as much as its committees actively enact. Certain committees have accomplished very little this year. Reports from each MAG committee chairman will soon be due for presentation before the House of Delegates at the '54 Annual Session. Committee chairman are reminded that a dormant committee will have little or nothing to report, and the committee chairman will not have fulfilled the obligations of his office. There are two months left for committee chairmen to go into action. The Headquarters office will gladly assist any committee chairman who wishes to activate his committee during the remaining two months.

Birth Certificates

As of January 1, revised live birth and fetal death certificates have been instituted by the State Board

of Health. All changes made in the revised form were done in conjunction with the MAG Maternal and Infant Welfare committee. The new forms are easier for the physician to fill out and provide more accurate clinical information for study.

Medical Forums

As held so successfully in Atlanta in the winter of 1953, the Medical Forum program will be held on a statewide basis in 1954. With the aid of the MAG Public Relation committee, County Societies in Athens, Columbus, Savannah, Rome, Waycross, Thomasville, Macon and Atlanta are planning to sponsor Medical Forums. These forums present panels of local physicians who discuss current medical problems on a question and answer basis. The public is invited to attend.

Bricker Amendment

Have you expressed your views on the Bricker Amendment to your congressman? Proposed changes in the Constitution of the United States are at stake. It is an important issue before Congress. The *Journal of the AMA* editorially supports the Bricker amendment because the amendment aims to prevent domestic government from being circumvented by simple treaty with foreign nations. In other words, Sen. Bricker's proposed amendment would protect the states and the people from abuse of the treaty-making authority and safeguard the American people against living under laws imposed by international authority, particularly when such laws take precedence over and even conflict with our own American laws, including the Constitution of the United States.

As responsible persons in the community, physicians should familiarize themselves with the facts on this proposed amendment—and express their views to their Representatives and Senators in Washington.

Social Security

Some of the most influential social security planners still think that physicians and other groups should be blanketed in at this time. Chairman Daniel A. Reed (R., N.Y.) of the House Ways and Means Committee has indicated that in his opinion Congress shouldn't force mandatory social security coverage on physicians and others who don't want it. The administration bill, introduced last August, would take in physicians, dentists, farmers, and all other groups self-employed. Despite Mr. Reed's attitude, this is not the time for undue optimism. Make your opinion known to your congressmen now.

Milton D. Krueger
Executive Secretary

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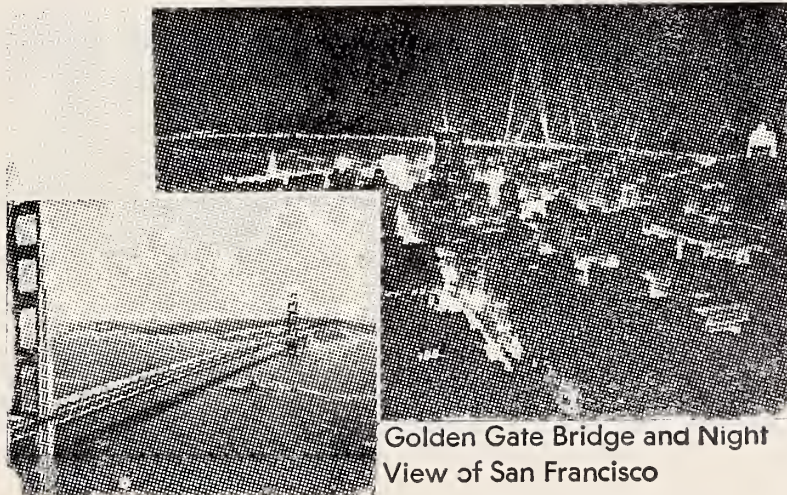
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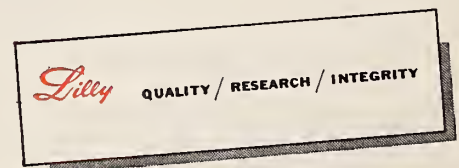
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SODIUM RESTRICTION has become an important part of our therapeutic armamentarium in internal medicine. The 200 mg. sodium diet in edema associated with liver and kidney disease, and particularly with heart failure is most valuable. Salt restriction in hypertension must be very severe to be of any benefit—50 to 150 mg. daily as in the rice diet.

In surgical patients we know that sodium intake should be limited during the first seventy two hours after operation.

As long as kidney function is adequate, sodium restriction in medical and surgical patients is safe, since the kidney tubules are so constructed to conserve sodium that they can elaborate a urine which is practically sodium free. If the tubules cannot make ammonia to exchange for sodium ions and if they cannot exchange H^+ ions for sodium ions, limitation of sodium may produce a serious deficit. This occurs especially in hypertensive patients because they are prone to have diminished kidney function. The hypertensive individual with good kidney function should excrete less than 100 mg. of sodium (test for chloride if sodium determinations cannot be done) daily after the first four days of the rice diet. If more is excreted, then the patient must receive that much more.

With advanced heart failure and cirrhosis of the liver there is a tendency for the kidneys to retain water irrespective of any sodium depletion. Severe sodium limitation accompanied by the administration of frequent mercurial diuretics will cause serious sodium deficiency.

Removal of ten liters of ascitic fluid removes roughly fifty six grams of salt. If the patient has unlimited access to water and is on a very low salt intake he can produce a dangerous reduction in the sodium concentration of his body.

The surgical patient is usually safe from loss of

sodium since the stress of operation acting through the adrenal cortex causes salt retention by the kidneys. If diarrhea, gastric suction, or any fistula containing digestive juices is present, the body has no protection from large daily losses of salt. One must learn the magnitude of these losses and replace them to prevent severe electrolyte depletion.

The signs of salt depletion are oliguria (less than 500 cc. of urine daily) weakness, drowsiness, nausea and vomiting, mental depression, and coma. Death will occur if these warnings are ignored; death may occur after treatment, if it is started too late.

In advanced heart failure and portal cirrhosis, or if large ascitic deposits are removed, salt restriction must be accompanied by water restriction to avoid dilution of sodium.

If mercurial administration fails to produce a good diuresis, this is a warning that salt depletion may be taking place since salt will be excreted even in the absence of much water excretion.

Once sodium deficiency is produced one cannot rely upon normal saline to correct the deficit; so much water has to be given in this manner that acute pulmonary edema may result before the sodium level is brought back to normal. One must use five or six per cent sodium chloride intravenously while at the same time *limiting water intake*. Two hundred cc. are given first and the response of the patient noted. A good response encourages further administration at the rate of about 300 cc. every twelve hours. Too rapid reconstitution of the defect does not give the body a chance to make adjustments and may cause death. As sodium deficit is made up, potassium lack may become evident when water comes out of the overhydrated cells and dilutes the extracellular fluid. If weakness, mental symptoms, and absent reflexes appear, this possibility should be checked for and corrected.

P. S. R. A. ROSTER

FOUR PAGES in the back section of the JOURNAL this month are subscribed to by members of the Professional Service Representatives Association. We are happy to publish the roster of their membership in the same issue with a list of our own members.

These members of the P.S.R.A. represent most

of the ethical pharmaceutical houses of America. Many of their companies advertise in the JOURNAL and support it. We recommend these men to the physicians of Georgia.

The Medical Association of Georgia extends its heartiest best wishes to each member of the P.S.R.A. We hope that 1954 will be another year of continued cooperation between the two organizations.

New Live Birth and Fetal Death CERTIFICATES

PHYSICIANS ARE NOW responsible for reporting every abortion and stillbirth which occurs in their practice. Under the revised State Vital Statistics Act, effective January 1, 1954, every recognizable fetal death regardless of length of gestation should be reported.

In February 1953 the General Assembly amended the State Vital Statistics Act and replaced the term "stillbirth" with the definition of "fetal death" as adopted in 1950 by the Third World Health Assembly. This definition of fetal death, shown below as it is written into the Georgia Act includes all abortions regardless of length of gestation and all stillbirths.

"Fetal death prior to the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of pregnancy; the death is indicated by the fact that after such separation, the fetus does not breathe or show any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles."

Much progress has been made during the past fifty years in the reduction of infant and maternal mortality and stillbirth rates. Much remains to be done. The rate of reduction of the perinatal mortality rate (all fetal and neonatal deaths) has lagged behind the rate of reduction of the death rate among older infants.

It has been estimated that one out of five pregnancies results in a fetal death. Applying this ratio to live births in Georgia, one estimates that more than 20,000 fetal deaths occur each year in the state. Contrast this figure with the approximately 2,000 fetal deaths which have been recorded annually under the stillbirth registration system. Indications are that 90 percent of the fetal deaths occurring in Georgia have not been recorded in the past.

It is very important to know something about these unregistered fetal deaths.

The registration of all fetal deaths as recommended by the World Health Organization will make it possible to obtain comparable statistics for different areas of the world and even for states in the United States. This registration also will show us in Georgia where our efforts should be directed.

Registration of all fetal deaths is another means of extending the attack on the allied problems of maternal and perinatal mortality and morbidity. The reporting of all fetal deaths by physicians is necessary to provide information showing the magnitude of the problem, the distribution among the various population groups, and some of the social and economic factors involved. However, a full understanding of these problems, especially fetal and neonatal losses, and how they can be controlled, can come only from extensive medical research.

Reporting is essential. A "Fetal Death Certificate" and a revised "Medical Report of Live Birth" form have been prepared by the State Health Department with the cooperation and advice of the Maternal and Infant Welfare Committee of the Medical Association of Georgia. Copies of these forms and explanatory materials have been sent to every physician by the Division of Vital Statistics of the State Health Department. (If further information is desired contact the State Health Department.)

Physicians are the source of information to further define this problem of fetal and neonatal mortality. The completeness and quality of the reports will determine the accuracy with which the problem can be defined.

MAG Maternal and Infant Welfare
Committee and Georgia Department
of Public Health

The Executive SECRETARY'S *Letter*

THE EXECUTIVE SECRETARY'S LETTER appears for the first time in this issue of the JOURNAL. Printed on yellow paper to attract your attention, this page will appear each month in the front section of the JOURNAL. The letter will carry important and timely information of medical interest. Some items will concern your County Medical Society and its activity; other items will inform you of the State Association's program and plans, and still other items will give you medical news of national importance.

Each news item carried on this page has been

carefully screened and merits your attention. Only matters of immediate and particular note will be discussed. And these subjects will be brief for quick and easy reading. The EXECUTIVE SECRETARY'S LETTER will give each month at a glance topics affecting Georgia physicians.

In editing such a page, the staff of the JOURNAL can obtain this information for you, the material can be written for quick and easy reading, the page can be prominently displayed to attract readership, *but* the final link with the physician is his perusal of this material.

Diagnosis of

CARCINOMA *of the* PANCREAS

H. H. TIFT, M.D., Macon

FAILURE TO RECOGNIZE the presence of carcinoma of the pancreas is a very common diagnostic error. At times the diagnosis is most difficult and will be missed by men of unquestioned clinical acumen. For example, Hunter,³ in a study of diagnostic errors in clinicopathological conferences at the Massachusetts General Hospital during a twenty-five year period, found that carcinoma of the body of the pancreas was diagnosed correctly during life only one time in twenty-five years, and cancer of the head of the pancreas in only fifty percent of the cases. On the other hand, the diagnosis is often missed in obvious cases simply because the examining physician is not familiar with the usual clinical and laboratory findings in this entity. It is the purpose of this paper to review the clinical picture of carcinoma of the pancreas and to try to stimulate more interest in this disease.

In 1935, Whipple⁸ performed the first successful pancreatoduodenal resection. Since that time there have been many improvements in the technic in this procedure and the operative mortality rate has been lowered to a figure that compares favorably with that of palliative surgery for this disease. In December 1952, Orr⁶ reported a collected series of seventeen cases who had survived five years or more following pancreatoduodenectomy for carcinoma of either the head of the pancreas or ampulla of Vater. While this may seem to be a small number, one must remember that without the benefit of surgery, these seventeen people would certainly have been doomed. The task of substantially increasing this figure is one not primarily for the surgeon, but for the general practitioners and internists, for it is they who usually see the patient first and hence have the opportunity and responsibility of making an early diagnosis.

The disease under discussion constitutes about one to two percent of all malignancies. It occurs most commonly in people who are over fifty, but cases even in teen-agers have been reported. It is more common in males than in females, the ratio being about 2.4:1, according to Berk.¹ The course of the disease is usually a rapid one, death occurring as a rule within one year after the onset of symptoms.

The outstanding symptoms of carcinoma of the pancreas are pain, weight loss, and jaundice.

It is the symptom of pain which will be stressed in this paper, for, despite the fact that in numerous reported series of cases pain has been shown to be one of the three predominant symptoms, nevertheless, its importance is still not appreciated by the average physician. Some 12 years ago Berk¹ asked each of 120 fourth year medical students, residents, interns, and general practitioners in practice less than five years to state "that feature which he most closely associated with and felt was most commonly to be found and expected in patients with carcinoma of the pancreas." Forty-three percent gave "painless jaundice" as their answer. Another forty-nine percent favored "jaundice," without qualification as to pain. To see if there has been any marked change in the thinking of young physicians along these lines, recently all sixteen members of the house staff of a three hundred bed city hospital were asked the same question. Of this group nine, or 56 percent, answered "painless jaundice"; one answered "indigestion," but when questioned further, said there was usually no pain; two answered "pain and jaundice"; and four answered "epigastric pain." From these answers, it seems obvious that teachers in our medical schools are still erroneously stressing painless jaundice as a common symptom of carcinoma of the pancreas. It is true that some cases of pancreatic malignancy have painless jaundice, but they are the exception rather than the rule. In reviewing the various reported series of cases, one finds that about three out of every four patients have pain.

The pain of carcinoma of the pancreas has no special characteristics by which it may always be recognized. Nevertheless, many authors have stressed the frequent occurrence of constant epigastric pain, radiating through to the back, and varying in intensity with body position. The patient will often report that the pain is relieved by a sitting position and aggravated by a supine position. Hence, the pain may occur largely at night. Indeed, such a history should immediately suggest to the examining physician the possibility of a pancreatic malignancy. At times, instead of being constant, the pain will occur in paroxysms, during which the patient may cry out because of severe, colicky pain in the middle portion of the abdomen. Attacks of this type are sometimes referred to as celiac neuralgia.

At other times, the pain may be aggravated by food, and hence may simulate a peptic ulcer. In such a case, particularly if the gastro-intestinal x-rays are normal and the patient is in the older age group, carcinoma of the pancreas is a distinct possibility.

Unaccountable weight loss occurs in a large majority of the patients and it is both rapid and severe. A loss of twenty-five pounds over a period of three months is not at all uncommon and such a history in a patient over forty years old should always make the physician consider carcinoma of the pancreas in the differential diagnosis.

Jaundice, of course, is also an important symptom and may occur early if the lesion is near the common bile duct. The jaundice is progressive in type and is usually accompanied by severe generalized pruritis. Contrary to the general impression that many physicians have, the jaundice is painless in only about twenty-five percent of the cases.

Other important, though less characteristic, symptoms include anorexia, nausea and vomiting, constipation, indigestion, excessive "gas," weakness, diarrhea, and bulky stools.

The physical examination of patients with early carcinoma of the pancreas is not likely to be helpful. Indeed, it is likely to be entirely negative at the time of onset of symptoms. Later on, one may find jaundice, ascites, a palpable gallbladder, an epigastric mass, hepatomegaly and fever.

An interesting finding, although usually a late one, in many patients with pancreatic malignancy is the occurrence of multiple venous thrombosis. Sproul⁷ was the first author to point out the frequency of this phenomenon, the mechanism of which is not fully understood. Since her original description, other reported series have confirmed the fact that multiple venous thrombosis occurs with sufficient frequency to make its presence a helpful diagnostic sign.

Like the physical examination, x-ray studies of patients with early carcinoma of the pancreas are characteristically negative. Later, barium contrast studies will frequently reveal deformities in adjacent structures . . . usually the stomach and duodenum . . . as a result of displacement or invasion by the malignancy. The important thing to remember here, however, is that negative gastrointestinal x-rays do not rule out a diagnosis of carcinoma of the pancreas.

Laboratory studies may be helpful, though they are seldom, in themselves, diagnostic. Perhaps the most useful aid introduced in recent years has been the demonstration of malignant cells in Papanicolaou-stained preparations of material obtained by duodenal aspiration. Lemon and Byrnes⁵ stressed the value of this test and recommended its use as a diagnostic office procedure soon after the onset of symptoms, rather than as a confirmatory measure in advanced cases.

Innerfield and Angrist⁴ have recently described a new test for cancer of the pancreas associated with jaundice. They found markedly elevated plasma antithrombin levels in pancreatic carcinoma patients with obstructive jaundice due to acute biliary tract

disease. These authors postulate that the previously-mentioned thrombo-embolic phenomena which occur in these patients may represent failure of a naturally occurring thrombin inactivation mechanism.

Elevation of the serum amylase, or more often, the serum lipase, is present in some cases and is helpful suggestive evidence. And glycosuria, hyperglycemia, and a diabetic-type glucose tolerance curve are common findings. The sedimentation rate is usually elevated and there is frequently an anemia and leukocytosis.

Brown et al.,² in reviewing a series of one hundred autopsied cases, have stressed the importance of the diagnostic value of a thorough examination of the stool. They point out that increased bulkiness of the stools and the presence of visible, butter-like, masses of fat in the stools constitute strong evidence of pancreatic insufficiency. And on microscopic examination of the stool following a diet that is high in rare beef, the presence of large numbers of yellow muscle fibers with sharp edges and with well-preserved striations is equally good evidence.

Patients with carcinoma of the pancreas frequently exhibit a marked emotional disturbance during their illness. They often become extremely depressed and anxious, have difficulty in sleeping, and may have a feeling of impending disaster, even before a diagnosis has been established. Such mental symptoms, if accompanied by abdominal and back pain, may be a good clue to the diagnosis of pancreatic malignancy. And much too often, these unfortunate individuals are given an erroneous diagnosis of psychoneurosis, simply because they continue to complain, despite normal physical, laboratory and x-ray findings. Many of these patients have been given various forms of psychiatric therapy, including shock treatments, only to find out later, and much to the embarrassment of the physician, that they are suffering from pancreatic carcinoma.

One can readily see from the above discussion that cancer of the pancreas in its early stages may be present in a patient past middle age who presents himself with a history of unexplained weight loss and with abdominal pain which is related to body position. Such a patient may have a negative physical examination, negative x-ray workup, and normal laboratory findings. This patient should have the benefit of an exploratory laparotomy, for only by following such a course will the surgeon be able to save a significant number of these individuals. Since an exploratory laparotomy, in itself, carries such an extremely low mortality rate, it is felt that under these circumstances the operation is justified, despite the fact that in many cases the findings will be negative.

Too often patients with carcinoma of the pancreas are not seen by a physician until their disease has advanced to an inoperable stage. It behooves every physician, therefore, to be familiar with all of the signs and symptoms of this disease, so that when he observes a case, regardless of the stage it has reached, he will recognize it, and not make the mistake of labeling it psychoneurosis.

CASE REPORT

The following case report illustrates some of the clinical features of carcinoma of the pancreas: B.R.W., a fifty-eight year old white male, was first seen on April 29, 1952, with the chief complaint of pain in the left upper quadrant of the abdomen. This pain had been present almost constantly for four months. It was described as "boring" and radiated straight through to the back. The patient volunteered the information that the pain was worse when he lay down, but was somewhat relieved when he sat up and leaned forward. In addition, he complained of poor appetite and of weight loss of fifteen pounds. He was extremely nervous and depressed, cried easily, and said he was afraid he had cancer.

Physical examination was not remarkable except for a mass in the left upper quadrant which was thought to be a slightly enlarged spleen.

G. I. Series and barium enema were negative except for some evidence of enlargement of the liver and spleen. Sedimentation rate was 36, with a hematocrit of 38. White blood cell count was 13,000, with 71 percent neutrophils, 21 percent lymphocytes, 3 percent monocytes, and 5 percent eosinophils. The blood smear was normal. Stool was negative for occult blood, ova and parasites. Urinalysis was normal.

A tentative diagnosis of Hodgkin's disease was made and an exploratory laparotomy advised. This was performed on May 24, 1952 by Dr. William R. Baker of Hawkinsville, Georgia. At operation, the spleen was found to be normal, but there was a mass measuring six by ten inches in the tail and part of the body of the pancreas, and involving the posterior wall of the colon and stomach. Biopsies were taken and no attempt was made to remove the tumor. Microscopic section revealed poorly differentiated adenocarcinoma of the pancreas.

The patient became progressively weaker and died on July 1, 1952.

Summary

A review of the clinical picture of carcinoma of the pancreas has been presented. The frequent occurrence of abdominal pain, radiating through to the back, has been stressed, along with the frequent absence of conclusive physical, x-ray, and laboratory findings in early cases. A plea has been made for wider use of exploratory laparotomy to rule out this diagnosis in suspected cases. An illustrative case is presented.

765 Spring St.

Discussion

J. Benham Stewart, 700 Spring St., Macon: Those of us who do surgery are frequently blamed for wanting to operate on every patient we see and so a great burden is being taken from our shoulders when a medical man recommends surgery so wholehearted-

ly. The prognosis in cancer of the pancreas has always been dismal. Most men feel that they are 100 percent fatal, but like all cancer we will only make progress in treating them when we can diagnose them early. Ampullary malignancies are curable by surgery and these are usually the tumors which produce the painless jaundice.

By the time most pancreatic cancers can be diagnosed, and explored, even palliative surgery is out of the question. We have certainly explored to the limit the so-called conservative handling of these deadly tumors and it seems only fair to try a more aggressive approach in the hope that exploration for the earliest symptoms will reveal operable cancers. I should like to add this word of caution. The pancreas is one of the most difficult organs of the body to examine, even with the abdomen open, and the Whipple operation is a formidable procedure and not to be undertaken lightly.

Let me add my plea to Dr. Tift's that we learn to think of the pancreas when we see the patient with unexplained weight loss, but more especially with pain in the epigastrium radiating to the back, as much as we do when we see a patient with the much publicized painless jaundice. Far more pancreatic lesions will display the former than the latter symptoms.

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Committee Needs Scientific Exhibitors

By the time you read this, all titles of papers to be read at the 104th Annual Session at Macon in May will have been submitted to the Committee on Scientific Work.

The program is now completed as far as the

scheduling of scientific papers is concerned. There is still space available for physicians interested in presenting scientific exhibits at the Annual Session. Please write direct to Committee on Scientific Work, 875 West Peachtree St., N.E., Atlanta, Ga.

Practical CONSIDERATION

of

BLOOD MALIGNANCY

JACK C. NORRIS, M.D., Atlanta

MANY HEMATOLOGISTS consider the term leukemia to be not easily understood by the public. Leukemia means, of course, an increase in the white blood constituents. On the other hand, the disease is often of a character where the leucocytes may become seriously decreased. A more suitable name for the disease would be "malignancy of the blood" or blood cancer.

Leukemia was described by Donne and Barth¹ in 1839. Each year more than 6,000 persons die from this disease and there is a possibility that the number is increasing. The condition causes five times more deaths than does poliomyelitis, and twice the mortalities of measles, scarlet fever, whooping cough, or diphtheria.

Biological Facts Concerning Leukemia

Leukemia occurs in and can be also transmitted to chickens, guinea-pigs, and rats.² The blood picture is practically identical with the cell features in man, and is accompanied by anemia, a tendency to hemorrhage, and damage to the liver and blood clotting mechanism. The disease cannot be transmitted by the blood serum or by filtrates made from the cells; thus, if a virus is the causative agent, it is incompletely dissociated. The cells lose their disease-producing ability when exposed to radiation. Experiments also indicate that some animals are resistant to leukemia, while others may be very susceptible, suggesting that there may be humoral factors present. One might assume that leukemia is hereditary. Maternal influences may be more important than paternal. Leukemia can be produced in animals by toxic or external agents, such as x-rays, benzol, methylocholanthrene, benzy-pyrene, and possibly certain estrogens.³ Experiments show that while animal and human leukemias are practically identical, there is one remarkable difference—leukemia has never been transmitted from human to human by inoculation.

In a classification of the leukemias, this simple grouping should suffice: (1) myeloid, (2) lymphoid or lymphatic, (3) monocytic, (4) eosinophilic, (5)

plasma cell, and (6) histiocytic. From a practical view point, the last three types are quite uncommon, and rarely observed. Pathologically, one need only remember that myelogenous leukemia is a disease of the bone marrow, while lymphatic leukemia is a disease of the lymphoid reticular structures. In all probability, polycythemia is of a "leukemoid" character, in which the erythrocytes are enormously reproduced until they become physiologically unendurable. To clarify the problem, the above forms should be divided into (a) an acute process, or (b) chronic; and we also note that any of the leukemias may have aleukemic phases. There are no absolute criteria to determine when the disease is chronic or acute except clinically, and even then, it is often impossible to determine the onset. On occasion an initial blood count, only slightly above normal in a patient, has been followed by increases of 12,000 to more than 140,000, with death occurring four to five years after the patient first came under observation.

One patient, a young man in his thirties, had no great symptoms of importance until the last few months of life. During the first three years the patient played golf several times weekly and was in a professional tournament in the last six months of life. Furthermore, his spleen was barely palpable and enlarged peripheral lymph nodes were never observed. The patient's primary complaint was of weakness. He could not point to anything definite. After much inquiry it was determined that onset had probably occurred three to four years previously. His symptoms apparently occurred long before the blood picture developed. Unquestionably, we see people acutely ill, who go rapidly downhill, and in a few months are dead. In the aleukemic stages, the problem is often confused with other diseases such as aplasia, intoxications or influenza, and possibly leukopenic phases of mononucleosis or agranulocytosis.

Pathology of Leukemia

Myeloid leukemia is associated with a profound stimulation of the bone marrow leukocytes. When the new cells are shunted into the blood stream in enormous numbers several things may happen. First, the excess cells must be disposed of either through the lungs, intestinal tract or absorbed in ways that we know little about. The enormous cell activity necessarily blocks the circulation and impairs cellular nutrition, producing something akin to white blood sludge. The greatest damage from this is probably found in the capillaries of the spleen and the liver. As long as the new cells are disposed of, however, little of serious import develops. Lymphatic leukemias produce a similar disorder with this difference: instead of cells coming from the bone marrow, they reverse the process and invade the marrow systems. This is one point in which bone marrow studies may be important in diagnosing lymphoid leukemia. Both diseases cause congestion, and the same tissues in general are affected, but in the lymphoid leukemias, almost always one may find enlarged nodes and a palpable spleen. As a rule the larger the spleen, the more significant its chronicity. In the more acute form the nodes and spleen are less likely to show much enlargement. In addition, to mechanical factors, there is apparently a toxic principle discharged into the tissues. This toxin or whatever it may be (protein, complex molecule, disintegrating cellular elements, or virus) makes the patients very ill. A sequence of events may follow with formation of small thrombi in viscera, alterations in clotting mechanism and hemorrhages from all mucous membranes. Retinal hemorrhages with blindness also may occur.

Experience has shown that most of the acute and undifferentiated leukemias occur in childhood. Ward, in his report, found the highest peak of incidence at five years of age, with the next peak occurring between the ages of ten and twenty. Chronic lymphoid leukemia occurs most often between the forty-fifth and sixtieth year, while the chronic myelogenous variety appears most often from thirty to forty years. As for the mortality figures, in the unquestioned acute leukemias, the death rate is one hundred percent, usually within five to eight months. Chronic leukemias may survive for five years, though some may live longer, even for twelve to fifteen years. As far as is known, no one has reported a case of cured leukemia. Of twelve to fifteen leukemias in young, middle-aged, and older patients observed since World War II, all are dead except three.

The vast majority of leukemias are those of the myeloid and lymphatic groups and it is with these types in mind that we consider the clinical features of the disturbances. Some leukemics survive for long periods with few symptoms, and the diagnosis is often made from repeated hematologic studies. However, we find as a usual thing, the symptoms are these: (a) enlarged nodes and spleen or liver, variable in degree; (b) progressive normocytic anemia; (c) pallor and dyspnea, and (d) weakness. Other symptoms are hemorrhages from oral cavities, diseased gums,

throat lesions, and petechial hemorrhages. Fever occurs occasionally. We have been impressed most in our patients by two things: (1) weakness and (2) cough, especially in the acute cases. This is a violent type of cough, in which one would expect much expectoration, but there is little. In the period preceding death, the anemia may become profound, the white blood count very high, respiratory and cardiac failure extreme. A sudden hemorrhage may occur, the spleen may rupture, and death follows quickly.

We come now to deal with actual management. It seems well to take each case as an individual problem, and to decide what the patient needs at the moment. Blood transfusions must be given cautiously. When the blood count is around 3-4,000,000 cells, one may temporize. Of course, severe hemorrhage must be combatted with the use of blood. The diet is not restricted, and the patient is allowed to have what he wants to eat. Protein balance and proper elimination are essential. In adults, one frequently sees prompt improvement following removal of foci of infection, such as diseased teeth, tonsils and infected sinuses. Unless the patients are very ill and confined to bed, their activity is not restricted, but the physician must be cautious of an enlarged spleen which may rupture or undergo thrombosis. It is necessary to encourage leukemics as much as possible.

Value of Bone Marrow Studies

The value of bone marrow studies in leukemia is sometimes misunderstood. This technical aid is being overdone. Bone marrow studies should be made whenever all platelets have disappeared from the circulation, and before splenectomy is to be performed. Smears will also disclose either hyper or hypoplasia of the elements, and on some occasions with the appearance of lymphocytes therein, aids in confirming the diagnosis of lymphoid leukemia. On the other hand, bone marrow punctures may be dangerous, and more often than not are poorly done. Several deaths have been reported from accidental cardiac puncture, and infections have followed the procedure. Kracke often questioned the value of marrow studies. He stated that unless a representative segment of bone could be obtained, a true hematologic impression from the marrowgram could not be achieved. For many years marrow smears were made on all necropsies, and metastatic cancer was found in one patient, tuberculosis in a second, and malarial parasites in a third. However, in the leukemias the studies often clouded the issue. Of the patients observed since 1947, in no instance was it felt that bone marrow studies were necessary. As is often the case, leukemic patients become frightened, and rightly so. They go from one specialist to another, until a physician does a marrow puncture and ends up with the same diagnosis that has previously been made.

It is not the intention of this paper to leave the impression that bone marrow studies are disapproved of as a hematologic aid. However, it is thought that there is a time and occasion for the

procedure. The problem is a surgical one. There can be little question that the importance of marrow punctures are being exaggerated and are often done for financial gain and drama, rather than for essential information.

Therapy

For a number of years, the value of radiation has been known. Many feel that x-ray is the sheet anchor in the management of leukemia. This phase of treatment is also overdone and is to be cautiously used. X-ray therapy should be put off for as long as possible. X-ray should only be given by a radiologist who is thoroughly competent. As long as the excess white cells are tolerated, and the nodes not too unbearable or unsightly one should avoid x-ray therapy. It is also a dangerous procedure when directed to the spleen, especially in acute leukemic phases of the illness.

Some of the new drugs in the treatment of leukemia include: *Radioactive Phosphorous* which may be given using 5 millicurie dosage, 2 to 3 cc. twice weekly, and repeat in two months if desired (it is best for chronic leukemia); *Nitrogen Mustard*, 0.1 mg. per kg. body weight for four alternate days may be helpful, but is better for Hodgkin's lymphoma (the dosage and the cell activity must be guarded closely); *Urethane* is claimed to be of value, though I am not impressed, the dosage being 0.3 gram. t.i.d. until ten tablets per day are reached. After the count has materially fallen, a maintenance dose of 1 gram is administered daily. *Folic acid antagonists*, such as *aminopterin*, are tolerated at 0.5 to 1 mg. daily, and many reports have been made claiming profound and exciting remission in both children and adults which may last for two years. Folic acid should be given simultaneously to prevent folic acid deficiency.

ACTH and CORTISONE. These agents are best given in dosage of 100 to 300 mgm of cortisone, and 200 mgm of ACTH for adults, two-thirds this dosage for children, given for about three weeks daily. Some physicians claim the results are as good as those obtained from using aminopterin.

A few personal observations about therapy. I am inclined to be "buggish" about foci of infections in leukemia. Attention has been called to the necessary removal of all possible sources of infection. As for antibiotics and their associated use, two leukemics have been observed who reacted dramatically when *CHLOROMYCETIN* was administered. One patient had a severe concurrent bronchitis and his count was 80,000. After this drug was given the cell count dropped to 30,000 and has remained unchanged.

Another patient, a child, had a similar response to *AUREOMYCIN*. The count would rise again after aureomycin was discontinued. Another young adult patient under observation is a leukemic who responds nicely after his sinus infection is treated by *penicillin*.

From a therapeutic viewpoint, I have become impressed more and more with the liver in leukemia. We all recognize the profound changes that ensue in

that organ, such as cloudy swelling, fatty invasion, jaundice, bile stasis and above all, the invasion of the structures by leukemic cells. After thinking this matter over, I searched for some remedy that might attack the liver alterations. I considered the possibility of a choline deficiency in the liver, and have given a few patients *methiscol*, which is composed of *methionine*, *choline citrate* and *inositol*. Two patients with chronic lymphoid leukemia stated that they felt considerably better after its use, and it was noted that in two instances scleral jaundice gradually disappeared. A paper has recently appeared in the JAMA, August 2, 1952, by Portis and Weinberg, in which they discuss choline in liver diseases, especially in fatty infiltration. Recently Engle of Alabama found that rats on choline deficient diets developed tumors in more than twenty-eight out of fifty animals. Not one of the control animals developed neoplasm. Kensler also thinks that crude liver extract in the diet as a supplement prohibits malignancy in animals. To summarize, the liver which has been much neglected in the pathologic physiologic development of tumors is now receiving more attention; and if we consider leukemia a blood malignancy, which it really is, then there may be more to choline therapy than meets the eye.

A recent interesting observation has also been made on polycythemia. A patient related that while on a sea trip, he took DRAMAMINE, and that he was astounded to note that his erythrocytes were reduced, and that he felt improved. He since, on his own responsibility, takes dramamine whenever he feels plethoric. This therapy also might be of significant importance.

One must not forget the value of iron, liver, B-12, tonics, etc. At times, synkavite may be given for hemorrhage. Intestinal hemorrhages are often most distressing and fatal; transfusions are necessary and urgent. In one instance, a patient was uncontrollable until he was given protamine zinc insulin. What this material did, we do not know. Fowler's solution is temporarily helpful.

Re-Evaluate Leukemia

The entire attack on leukemia from a management and therapeutic viewpoint should be re-evaluated, remembering that leukemia proper is not so deadly; it is the *complications* that kill. We should stop giving our patients "*research medicine*" until those drugs and chemicals now so commonly used are carefully evaluated in regulated and well controlled experimental hospitals. We cannot cure the patient regardless of what we do, but we can prolong life. On the other hand, we may hasten death. Leukemia is a paradoxical disease, and we must agree with Osler who stated that acute lymphoid leukemia is the most horrible of blood diseases. Sanford concludes that leukemia is a disease of the blood forming organs, and he further mentions that "some authors regard it as a neoplasm which metastasizes to the blood stream." Regardless of those facts, the condition is one of the most baffling which we encounter,

with a number of unusual reactions. In some patients the leucocyte count may reach great heights and yet the patient may not be very ill; or the blood cells may drop to aleukemic levels, and the patient may become very sick. In neither instance will the patients be much embarrassed until the destructive complications appear.

Some patients live a number of years and others die in a short time. It is dangerous to anticipate just when death might occur.

Summary

Leukemia, therefore, is a cancerous condition in which the normal hematologic relationship and he-

matic balance is thrown out of gear by some substance leucocytes or lymphocytes to high levels. Or the reverse occurs, and the exciting agent suddenly pushes the cells to abnormally low numbers, to the stage of leukopenia. If we understood what this substance was, we would be much nearer the cure of the malignancy.

138 Doctors Building

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Polio Fighters Open Fourth Front

America has opened the "Fourth Front" in the long war against a tough and elusive enemy—polio-myelitis.

After 16 years of defensive fighting on the three fronts of research, patient aid and education, the American people—with the National Foundation for Infantile Paralysis as their high command—have now taken the offensive for the first time with the opening of the Fourth Front—polio prevention.

The weapons of the Fourth Front are two-fold:

Gamma Globulin, the precious blood derivative which gives a degree of temporary protection against paralytic polio, and a trial vaccine, which would provide longterm immunity.

Gamma globulin—GG—already is in the field with hundreds of thousands of individuals inoculated during 1953 and plans for doubling the supply in 1954.

The trial vaccine is now on the proving ground, with tests under way to determine whether it will do the job.

In 1953 the March of Dimes reached an all-time high of \$51,500,000. The heavy cost of caring for polio patients, of financing scientific research, of training professional people and of buying gamma globulin exhausted even this considerable fund before the year's end.

In 1954 the gamma globulin and vaccine programs alone will cost an estimated \$26,500,000. And the fight on the three earlier fronts goes on without pause.

Leaders in the fight estimate that at least \$75,000,000 will be required to carry the battle through the year ahead.



The nation is now nearing the close of six years of continuous high polio incidence. Scores of thousands of crippled individuals still need care and treatment. And the polio fighters also must proceed on the grim certainty that thousands more will be stricken before the Fourth Front armies push to final victory.

INTERVERTEBRAL DISK *Syndrome*

LOUIS A. HAZOURI, M.D., Columbus

AS EARLY AS 1864, Lasegue,¹ commented upon the physical signs of sciatic neuritis. Virchow, in 1857,² has been thought to be the first to comment upon the traumatic rupture of the intervertebral disk. By the detailed studies of Mixter and Barr, the origin of the ruptured intervertebral disk secondary to either trauma or degeneration was conclusively established.² Improvement in operative techniques have been contributed to by many, particularly Semmes and Love.¹ With the accumulation of clinical material, nerve root localization by Foerster and Keegan, and in particular, the early introduction of lipiodol contrast radiography by Sicard and Forestier,² the more precise localization of the ruptured intervertebral disk has gradually come about. The introduction of pantopaque contrast media as a substitute for lipiodol has still furthered the facilitation of performing myelography.

The presentation of the syndrome of rupture of the annulus fibrosus, with herniation of the nucleus pulposus in its various sites of the vertebral column, must of necessity be limited in a presentation of this nature.

Those disks which are herniated in the lumbar region comprise some eighty to ninety percent of the entire disk problem. The intervertebral spaces between the fourth and fifth lumbar vertebrae and the fifth lumbar and first sacral joint account for ninety to ninety-five percent of the total disk pathology picture in the lumbar region.

The history of trauma associated with acute low back pain and sciatica, may concisely present, in the majority of cases, a working supposition of a torn annulus fibrosus with disk protrusion. This presents the greatest number of patients, though there are many who present recurrent attacks of low back pain with subsequent sciatica. However, this particular group does not present to the examining physician a picture as dramatic as does the first group mentioned.

Demonstration of many nerve fibers in the annulus fibrosus and in the posterior longitudinal ligament by Rooft,² readily explains the acute back pain which occurs on distortion of the normal structures. Back pain above or below the actual disk site is explained by recurrent nerve filaments anastomosing with nerve roots at higher or lower levels.

Pain, knife-like, or severe aching, with paresthesias, radiates into the lower extremity. Coughing, sneezing, stooping or sudden motion from a prone to a standing position or a flexed position, aggravates or precipitates such pain. Relief is usually obtained by lying flat in bed and is aggravated by walking. This is usually the reverse of complaints offered by many patients with neoplastic involvement of the spinal canal and its contents.

The sensory findings are predominantly those of loss, though on occasion hypersensitivity is present, and on many occasions, no sensory involvement can be discerned by the examiner. There are many factors involved which enter into the inability at times to make an accurate delineation of sensory findings, in particular that due to the marked pain from which the patient suffers. However, it may be assumed that as a quick method, in localizing the nerve root involved, those sensory findings involving the second through the fifth toe, particularly the fifth toe, indicate the first sacral nerve root, whereas involvement of the great toe points to the fifth lumbar nerve root as being the site of compression.

Muscular and reflex changes also help to localize the site of disk herniation. Weakness on extension of the toes, particularly that of the great toe, implies fifth lumbar nerve root involvement. Again, weakness of the tibialis anticus refers to fifth lumbar nerve root compression. These findings are especially important since reflex changes implicating the nerve root involved may not be in evidence as early as muscle weakness. Achilles reflex changes with gastrocnemius weakness denotes disease of the first sacral nerve root. Atrophy and fibrillations may occur. However, atrophy is usually associated with either prolonged nerve root compression or most commonly is due to disuse.

The remainder of the herniated disk syndrome falls into the cervical and thoracic regions. The cervical herniated disks make the greater proportion of this remaining group. They comprise some ten percent, although in our experience, this has been a higher figure, with involvement of some fifteen to eighteen percent.

Nuchal pain as well as many sub-occipital and frontal headaches must be likened to the back pain of the lumbar herniated disk. Frequent attacks of nuchal pain, labeled as fibrositis, wry neck and so on, not usually associated with the dramatic trauma, as seen in the lumbar site, are actually evidence of early disease of the intervertebral disk.² Many individuals cannot recall any episode of trauma.

Although the small herniated nuclei pulposi which occur in the cervical region are no larger at times than three millimeters in diameter as compared to the much larger lumbar disks, nevertheless they are potentially more dangerous. This is explained by the neural contents of the vertebral column at this site.

In the cervical region, the spinal cord accounts for most of the available space with the nerve roots usually passing at right angles into the foraminae. These are quite adequate for a normal environment but are easily encroached upon by the smallest of herniations. This potential danger is further enhanced by the stabilization of the spinal cord to the lateral walls of the spinal canal by the dentate ligaments. As can be seen, a herniation can easily cause severe spinal cord injury, by distorting the dentate ligament, even though it does not encroach upon the spinal cord itself.

In the lower lumbar vertebrae, this same situation does not occur. Here, the spinal canal is filled with the cauda equina and there is ample space for a massive herniation with, at times, not too great a neurological deficit. The cauda equina floats freely in spinal fluid and no dentate ligaments are present to hold down the free-floating nerve roots.

As implied by this brief description of the anatomy of the cervical region, there must, of necessity, be two syndromes involving the herniated intervertebral disk in this region.² Fortunately, the greatest percentage are those involving the far lateral herniations which impinge on the nerve roots. The most common sites for such an impingement are between the fifth and sixth cervical vertebrae and the sixth and seventh cervical vertebrae. However, the occurrence of a herniated nucleus pulposus between the seventh cervical and first thoracic vertebrae has occurred not infrequently.

The role of radiculitis, as in the lumbar region, plays a most important part in the complaints of the patient. Sharp radiating pain or boring severe aching-like pain presents itself. Pain originates from either the medial aspect of the upper third of the scapula or the nape of the neck into the shoulder. It then proceeds into the upper extremity, usually into the fingers. Aggravation is brought about by coughing and sneezing or movement of the neck. Electric-shock like paresthesia in the same distribution usually occurs. Of particular note is the absence of severe neck complaints. Actually, in a great number of patients the marked nuchal pain subsides prior to the radicular syndrome.

Tenderness about the involved vertebrae is present. Motor weakness involving the biceps brachialis muscle indicates involvement of the fifth and sixth cervical nerve roots. Motor weakness involving the triceps

brachialis muscle points to involvement of the seventh and eighth cervical nerve roots. Subjective or objective sensory involvement is most important in localization. Involvement of the seventh cervical nerve root usually affects the index finger in particular and often the medial portion of the thumb and second finger. Whenever impingement of the sixth cervical nerve root occurs, the dorsum of the thumb reflects sensory changes.

Of great importance is the foraminal compression test which consists of tilting the head and neck toward the painful side and applying pressure on the vertex of the head which is held in this position. This is positive when it reproduces the characteristic pain and radicular features of the lesion.²

In those cases of a midline herniation of the nucleus pulposus in the cervical region, the onset is usually that of an acute quadriplegia or quadraparesis or in the greater number of cases, a gradual loss of function in both lower and upper extremities over a long period of time. This is most often confused with a primary degenerative spinal cord lesion.

Thoracic herniated disks compose but a fraction of one percent of the entire group of herniated nuclei pulposi. This can be explained by the limitation of motion in this region as well as a much thinner interspace. However, for the same reasons given in the cases of cervical herniated disks, a lesion in the thoracic region is just as likely to give an extensive neurological deficit. Usually, the lesion gives either acute or progressive cord compression with paraplegic or paraparetic manifestations, acute or slow in onset. However, it has often occurred to us that cases of intercostal neuralgia may well be on the basis of a far lateral herniated nucleus pulposus in the thoracic region. Should this be borne out by further observations, the incidence of herniated nuclei pulposi in the thoracic region may well increase. Several cases have been brought to our attention presenting the symptomatology of acute intercostal pain with no succinct explanation being found. The myelogram shows no discernible lesion. Upon foramenotomy, a small pea-like herniation of the nucleus pulposus is found. The armamentarium afforded by the laboratory with the use of radiography and myelography is quite helpful in the diagnosis of herniated nucleus pulposus though at times, it can be misleading.

In the cerebro-spinal fluid studies, the total protein is elevated in sixty to eighty percent of the cases of herniated nuclei pulposi in the lumbar region. In those cases in which there is usually a very large herniation, evidence of sub-arachnoid space block is present as evidenced by cerebro-spinal fluid studies and jugular compression tests and myelography.

The plain radiograph is of utmost importance in ruling out other conditions, but not so much in the diagnosis of a ruptured intervertebral disk. The findings of a narrow interspace, reversal of the normal curve, scoliosis or rotation or hypertrophic changes, and rarely a calcified disk are merely confirmatory to the clinical impression, but are not diagnostic of themselves.

In eighty-five percent of the lumbar cases and some ninety percent of the cervical cases, the myelogram will show evidence of a herniated nucleus pulposus. The failure of the myelogram to be one hundred percent is explained by many factors. The technical deficiencies inherent in the procedure itself, the size and location of the herniated disk, and the interpretation of the myelogram, attest to this failure. Occasional false positive defects are seen and must be considered in the light of the history and clinical findings.

The differential diagnostic entities are manifold but briefly for each vertebral region the following may be considered.

In the cervical region, the scalenus anticus syndrome with or without cervical rib must be considered. Superior sulcus tumors of the lung, spinal cord tumors, metastases, blood dyscrasias, chronic inflammatory processes, syringomyelia, amyotrophic lateral sclerosis, combined system disease and syphilis with many other entities must be also borne in mind. This same group, with obvious exceptions, may well be extended to apply to the thoracic group of herniations.

In the lumbar herniated disk, especially if the history and findings are not typical, and even on rare occasions when the history and findings are typical, differential diagnosis may be quite difficult.³ In a few separate cases only close observation over a period of time will eliminate the etiology. Fibrositis, vertebral anomalies, fractures, tumor, primary or metastatic, intra-abdominal lesions, especially as related to hernia and renal in origin must be considered in the differential diagnosis. Obturator hernia, though rare, must be seriously considered and at times is impossible to differentiate from a lumbar herniated nucleus pulposus. Still further, of differential diagnostic significance are those cases of seminal vesiculitis. Glomus tumors, strategically located, may be quite challenging.

Therapy is always conservative with the initial insult. However, there is a clear exception to this rule—that of spinal cord compression or dramatic nerve root function loss. In this exceptional group

alluded to above, results depend on many factors, but of the most importance is the time factor. Immediate neurosurgical intervention is mandatory in cases of spinal cord embarrassment.

For the cervical herniated nucleus pulposus, halter traction or a modified neck support, will compensate the greater number of cases, in some seventy to eighty percent. However, should pain and marked neurological findings persist after adequate conservative therapy, neurosurgical intervention is indicated.

Those cases of lumbar herniated disks also must be treated conservatively. Complete bed rest, either on a flat bed or a modified Fowler's position, will alleviate much of the sciatica and back pain. Mechanical support with physiotherapy on regain of ambulation is of great adjunctive aid. Instructions against resumption of heavy duty labor must be advised. However, here again should conservative therapy be of no avail, neurosurgical intervention must be entertained. It is to be noted in particular that those cases in which compensation is considered, the closest scrutiny must be given. Though a bonafide objective presentation of a ruptured intervertebral disk be found, the ultimate perpetrations of the patient as to his malady must be a great factor in deciding which course of therapy to follow. The judicious use of analgesics and muscle relaxants goes far in relieving much of the patient's pain.

The question of fusion must of necessity arise in any disk discussion. I will only state that this is a most important adjunct in surgery of the ruptured intervertebral disk. It is only through the cooperation between the orthopedic surgeon and neurological surgeon that the proper selection of cases can be obtained with ultimate good results.

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Did You Know?

One hundred and twenty-eight maternal deaths in Georgia in 1952. Hemorrhage killed 48 mothers, toxemias killed 45 mothers and 21 mothers died of infections.

In this age of multiple weapons with which to diagnose and combat infections, 21 expectant mothers died of diseases caused by viruses and microorganisms. Penicillin, streptomycin, sulfa, "mycins," "icins," and other drugs were not enough to save the lives of these 21 young adults.

Did these mothers wait too long to contact a physician? Were facilities inadequate for making

the correct diagnosis for determining the most suitable antibiotic? Was the best antibiotic too expensive for the patient to obtain? Did the midwives fail to notify a physician? These are questions that come to mind in considering 21 deaths caused by infections.

No doubt some infections will not respond to treatment. However, in this age of antibiotics, 21 deaths caused by infection is too high. This number can be reduced. What can you do to lower this number of maternal deaths?

MAG Maternal and Infant
Welfare Committee

POISONING *In* CHILDREN

PRESTON D. ELLINGTON, M.D., Augusta

LEAD POISONING, epidemic and sporadic, have been reported for a number of years, and the sources of the lead involved in such poisonings are numerous. Water supplies conducted through lead pipes have been an important source of community poisonings. The use of lead-containing bath powders has caused lead poisoning in many infants and mothers. The perverted appetite of the child has accounted for the ingestion of lead from the side rails of gaily painted cribs and painted toys.

Lead poisoning is often caused by the use of discarded battery storage cases for fuel. The battery cases are impregnated with particles of lead sulfide which are vaporized when the casings are burned. These discarded cases serve as a good source of fuel and heat during times of family economic distress.

A case of lead poisoning from such a source is reported below.

CASE REPORTS

R. H. (U. H. 52-18968), a 14-month-old colored male was admitted to the hospital on December 11, 1952, with the chief complaint of "convulsions" and unconsciousness.

The mother stated that the child had been sick for about a month with an onset of anorexia and diarrhea accompanied by vomiting for several days. These symptoms improved slowly but the child began to lose weight. During the few weeks prior to admission the child became increasingly irritable when handled or approached, although he played contentedly when left alone.

On the day of admission the mother stated that while she was playing with the child he suddenly moved his head backwards, stiffened his body momentarily, then began to jerk all over with loss of bladder and anal sphincter control. The child was brought to the emergency room and given one-half grain of sodium phenobarbital and 3 cc. of calcium gluconate intravenously with control of the convulsive state. The child was then admitted to the hospital where he had several convulsive seizures with clonic movements of the left arm and leg, vomiting, and rotation of the eyes to the right. These seizures lasted for a few minutes and were followed by flaccidity of the left extremities and a slow waving motion of the right arm.

The past history revealed that the child had a normal spontaneous delivery. He was hospitalized at the age of four-months with severe diarrhea and dehydration. He contracted whooping cough at the age of five-months. The child was exposed during earlier life to active tuberculosis. There was no history of previous convulsions.

On further questioning the mother revealed that she had been burning battery casings for fuel in an open hearth for about three months.

The physical examination showed a well developed but poorly nourished colored male child of fourteen months in a state of unconsciousness. There was an almost constant slow waving motion of the right upper extremity across the face.

The anterior fontanelle was patent and normal to palpation and measured 1.0 cm. in diameter. The OF circumference was 46 cm. The pupils were round and equal and reacted sluggishly to light. There was a slight blurring of the left disc on funduscopic examination. The gum lines appeared normal. The mucosa of the pharyngeal arches appeared moderately inflamed. There were several small hemorrhagic areas on the right palatine arch.

There was no nuchal rigidity present. There was a mild lymphadenopathy of the submental, submaxillary, and upper anterior cervical nodes.

The lungs were normal to auscultation and percussion. The examination of the heart revealed normal findings. Abdominal examination revealed a visible sluggish peristalsis. The liver edge was palpable at the free right costal margin. The skin turgor and muscle tone were poor.

The extremities were grossly normal. The abdominal, knee jerk, and cremasteric reflexes could not be elicited. The biceps and triceps reflexes were considered hypoactive.

The following laboratory data was obtained.

RBC—4,240,000

WBC—13,850

Hgb—10.0 Gms.

The differential showed 86 percent neutrophils, 11 percent lymphocytes, 1 percent bands, and 2 percent monocytes. Blood smears stained with Wrights stain revealed approximately 2 percent basophilic stippling of the erythrocytes, moderate hypochromia, and basophilic chromatophilia of the erythrocytes. There was no stippling noted in a sickle-cell preparation. There was no sugar or albumin noted in the urinalysis. A blood sugar determination was 126 mg. percent. Examination of the spinal fluid showed 5 cells per cu. mm, and a total protein of 97 mg. percent. The X-ray examinations revealed strongly suggestive "lead lines."

The diagnosis of "acute lead poisoning with encephalopathy" was made. In spite of therapy the condition of the child became progressively worse and he expired approximately 64 hours after admission to the hospital.

Autopsy demonstrated considerable cerebral edema with a dusky discoloration along the distribution of the vessels, a bluish discoloration of the costo-chondral junctions of the thorax, a moderately dilated heart with a patent ductus arteriosus, and moderate dehydration. A subsequent report stated that findings were compatible with a diagnosis of acute plumbism.

Discussion

Lead may gain entrance to the body through the respiratory system by the inhalation of fumes containing lead sulfide, through the gastro-intestinal system by ingestion, or through the skin. It has been determined that a daily dosage of from 1.5 to 2.0 mg. of lead is distinctly hazardous and eventually will

cause poisoning in most individuals. Lead that is ingested may be excreted unchanged and even if absorbed may be carried to the liver and excreted in the bile. If large quantities of lead are inhaled, swallowed, or injected, the excretion does not maintain an equilibrium and lead becomes stored.

The form in which lead is transported in the blood stream is of interest and opinions vary as to whether it is carried as a diphosphoglucate, a complex inorganic phosphate with calcium and chlorine, as an albuminate, or as a soluble di-lead phosphate. Once lead is absorbed there is a characteristic distribution in tissues regardless of the route of absorption. It is distributed throughout the viscera but to the greatest extent in the spleen, liver, and kidneys. Gradually it collects in the bones probably as the very insoluble tertiary lead phosphate.

Symptoms of lead poisoning occur when the metal is bound in the brain or the liver or circulating in the blood stream. A rapid subsidence of symptoms is due to the removal of the lead from the circulation but does not indicate that the patient is out of danger as the metal is stored in the bones and under certain circumstances, such as subsequent infections, the lead may be released to enter the blood stream again.

Lead stored in the bones produces no deleterious effects except probably caries in the teeth. The effect of lead on the bone marrow may be so irritating as to ultimately produce definite changes resulting in a decreased output of normal blood cells, the release of immature red blood corpuscles, and a relative increase in the number of mononuclear leukocytes. There is one blood change that is generally considered of extreme importance as a sign of lead absorption. This change is the presence of basophilic stippling of the red blood cells. This stippling, or Grawitz's granules, may vary considerably in size from minute stippling to large aggregates of basophilic staining material within the cell. The prominence of these granules may be enhanced when using Wrights stain by doubling the staining time with a normal dilution time. The incidence of these stippled cells may be as much as 4 percent or more of the red cells. It is true that such cells may be found in the blood smears of persons suffering from other diseases but in no other disease are stippled cells so profuse in the absence of other major blood changes. They are very often the earliest sign in acute lead poisoning. This stippling has never been fully explained but they have been considered to be degenerated reticulocytes, juvenile red blood cells, or manifestations of polychromatophilia.

The finding of hematoporphyrin in the urine has been considered by some authorities as positive evidence of lead poisoning. The presence of albumin and granular casts in the urine is common.

Only an occasional blue line on the gum margins is present in children. A continuous lead line is seldom seen and the characteristic appearance when it is present is that of a punctate precipitate of black granules in the margin of the mucous membranes around the incisor teeth which are covered with tartar. A hand lens may be very useful in discerning

the presence of such deposits of lead sulfide in the gum margins.

The spinal fluid findings may be within normal limits or minimal changes may be present. These changes include slight rises in pressure, and an increase in the mononuclear cellular elements, or positive globulin reactions.

Roentgenographic evidence of the deposition of lead appears as abnormally dense bone at the growing ends of the shafts of long bones and along the growing margins of the flat bones in children.

Symptoms

The symptoms of lead poisoning in children vary with the duration and intensity of the exposure and with the susceptibility of the child. One of the earliest symptoms to be noted is a change in the disposition. He may become restless at night, irritable and peevish during the waking hours and complain of pain in the epigastrium and indefinite pains in the joints and muscles, especially in the legs. The appetite usually becomes poor. As the disease progresses, the abdominal pains are more severe and the child may become constipated.

The gait has been described as being characteristic in that it is a waddling type gait in which the child walks on the outside of his feet, drags his toes, and with each step he swings his legs sideways before putting his feet to the ground. The characteristic wrist drop seen in affected adults is uncommon in children. The facial and the motor ocular nerves are often involved. Optic neuritis due to the direct toxic reaction of lead on the nervous system, retinal hemorrhages, optic atrophy, or weakness of the external recti muscles may occur in children.

The temperature is usually normal although irregular elevations have been recorded and in terminal cases with cerebral manifestations the temperature elevations may be extremely high.

Lead colic and spastic constipation are not the only reactions of the gastro-intestinal tract during lead poisoning. There is also a tendency for involvement of the vascular system of the upper portion of the digestive tract which may lead to the development of gastric ulcers.

Perhaps the most dramatic manifestation of lead poisoning and at the same time one which is of the most serious prognostic import is the development of acute mental changes. Of the various forms of cerebral disorders, the convulsive seizure is considered the most common. The convulsion of lead encephalopathy is not at all pathognomonic although it is very persistent, tends to recur, and is attended by a high mortality. These convulsions may be local or general, mild or severe. The duration of the period between the first exposure to lead and the development of cerebral symptoms is variable. Lead is not usually found in the spinal fluid.

The residual effects of the toxicity of lead on the central nervous system are at times permanent and progressive. Encephalopathy seems to be quite common in young children. Mentality sometimes remains impaired with a tendency to mental sluggishness and melancholia even if survival occurs.

The macroscopic changes most frequently found in the brain are an edema and flattening of the convolutions. There may be congestion and thickening of the pia which is itself often adherent to the cortex. Hemorrhages and round cell infiltration within the pia and an increase in the neuroglia cells of the cortex may be present. In the peripheral nerve the axon and the whole cell may be destroyed. Edema of the optic nerve is common.

Summary

A case of acute lead poisoning in a 14-month old child is reported in which the source of the lead was fumes from burning battery casings. The literature on lead poisoning is briefly reviewed. The

aspects of therapy and "de-leading" have been purposely omitted.

University Hospital

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ESOPHAGEAL OBSTRUCTION

With Saraka Simulating Angina

TULLY T. BLALOCK M.D., Atlanta

The patient with anterior chest pain may confront the examining physician with a puzzling problem that often must be decided at the bedside. Sir William Osler continually admonished his students to pay careful attention to the stomach when a patient complained of heart pain.

It is not uncommon for a patient with an esophageal hiatal hernia to come to the physician because of a fear of heart disease. Indeed such a patient may pose a serious problem in diagnosis to the physician who is confronted with an equivocal electrocardiogram and symptoms of angina in a middle aged or elderly patient. A careful history, physical examination, electrocardiogram, and gastrointestinal x-rays may lead to an accurate conclusion. Sometimes, however, the problem is more urgent. Such a case is presented below.

The patient, a white male, 52 years of age, sat on the side of the bed and complained of severe pressing substernal pain. He stated that following an average meal he had taken a "handful" of Saraka and washed it down with a glass of water. About one-half hour later pain commenced and continued to grow worse. When examined, he was pale, ashen, perspiring profusely, and quite apprehensive. He complained of a choking sensation and inability to breathe. The pain was described as extreme pressure in the center of the chest radiating to both shoulders.

He was unable to lie down and was forced to sit erect in order to minimize discomfort.

Pulse rate was 110; blood pressure 150/80. Heart sounds were of good quality with a regular rhythm. No murmurs were audible. The lungs were clear.

The patient was transferred to the hospital by ambulance. On arrival he remained pale, sweating and in great pain. He complained at this time of moderate nausea. An emergency electrocardiogram was normal. The leukocyte count was 8000/cu. mm. with a sedimentation rate of 13 mm. per hour. Temperature was 98 F. and the pulse rate remained unchanged.

Further questioning revealed that the patient had experienced choking sensations during meals for several years past and on occasion had to leave the table and force himself to vomit before relief was obtained. He had taken Saraka for several years because of constipation.

The patient was taken to the fluoroscopy room for examination of the esophagus. Before this could be done he complained of severe nausea and vomited a golf ball size mass of thick gelatinous material looking very much like a wad of tobacco. See Figure 1. He was immediately relieved of his pain, felt completely well and wished to leave the hospital.

*Saraka is manufactured by the Union Pharmaceutical Company.



Figure 1

His color became normal, the pulse dropped to 80/min. and his sweating stopped.

The following day, an x-ray of the esophagus and upper gastrointestinal tract revealed a small hiatal hernia of the paraesophageal type. It is interesting to note that at the first examination in the trendelenburg position and with the valsalva maneuver the hernia could not be demonstrated. The patient had left the x-ray room when he complained of a choking sensation and was returned immediately to the x-ray room where the hernia was demonstrated. See Figure 2.

Because of the prolonged history of obstructive symptoms, this patient was advised to undergo surgical repair of the hernia. Surgical consultation was obtained and the hernia repaired through a left thoracotomy approach. In the six months since the operation, he has been symptom free.

Summary

This case is presented to illustrate one of the complications of a hiatal hernia: esophageal obstruction.

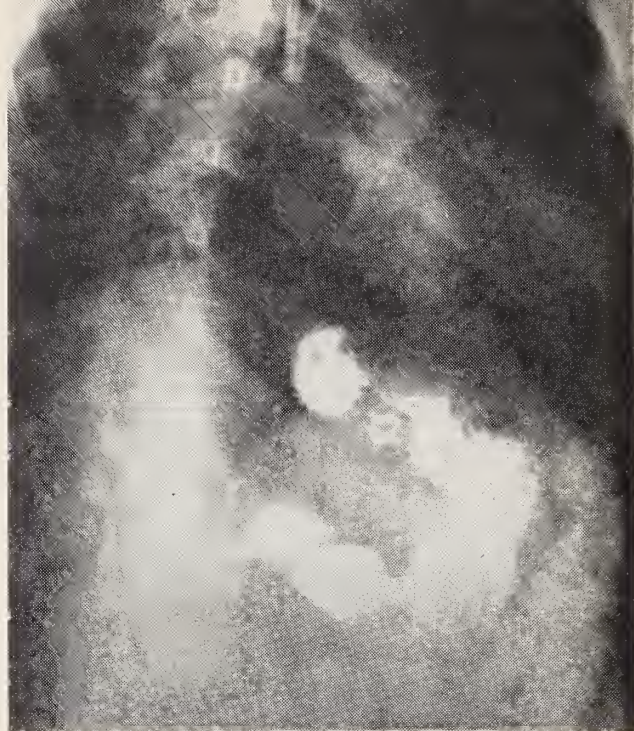


Figure 2

It could serve as a warning to these patients to solve their constipation problem by some other means than the use of the bulk-forming laxatives. Saraka* is a dry granular substance containing Bassorin and Frangula. The former substance is a gum derived from the sap of the tree *Sterculis Urens*. Frangula, a plant activator is a mildly cathartic element of Buckthorn bark. Saraka swells when wet to several times its dry volume. The box contains instructions to follow dosage with adequate fluids.

The similarity of this patient's early symptoms to coronary occlusion are striking. It is probable that the vagal stimulation of the obstructed esophagus might even produce sufficient coronary artery response to exhibit electrocardiographic abnormality. It is also possible for a hiatal hernia to be missed on fluoroscopy unless the patient is examined during a period when he has symptoms. The Trendelenburg position and the valsalva maneuver are helpful but may not force the hernia through a small opening.

Surgical repair of such a hernia represents an effective cure when symptoms are persistent or when a medical program of bland diet, antispasmodics, alkalis and elevation of the head of the bed has been unsuccessful.

490 Peachtree St., N.E.

Adair to Speak in Atlanta

Dr. Frank E. Adair, Attending Surgeon at Memorial and Ewing Hospitals in New York, and former President of the American Cancer Society, will participate in the Medical and Scientific symposium to be held for all Georgia Doctors beginning at 9 a.m. Friday, January 15th at the Academy of Medicine.

Dr. Adair will also address the meeting for local unit Board Chairmen and Presidents to be held Friday night at the Biltmore.

The symposium will include presentation of actual patients and panel discussion of diagnosis and treatment.

abstracts by georgia authors



Colhoun, F. Phinzy, Jr., 478 Peachtree St., Atlanta. Pigmentary Glaucoma and Its Relation to Krukenberg's Spindles. *Am. J. Ophth.* 36:1398-1415 (Oct.) 1953.

1. The Krukenberg type of corneal pigmentation is probably more common than is generally believed.

2. Six cases of chronic, simple wide-angle glaucoma with varying degrees of Krukenberg's spindles are reported. This association occurs predominantly in young myopic males of large stature. The clinical manifestation and course of the glaucoma in these cases was no different from that occurring in the same age group without Krukenberg's spindles, except that in one case the mydriasis provocative test produced a paradoxical elevation in intraocular tension, a characteristic described by Sugar.

3. In five patients with Krukenberg's spindles but no glaucoma, the mydriasis provocative test failed to produce a rise in intraocular tension and no free particles of pigment could be seen in the anterior chamber during the test. The measurement of the facility of aqueous outflow was normal in all cases. In two of the cases, however, the water-drinking provocative test was strongly positive, indicating a glaucoma tendency.

4. The author believes that corneal pigmentation of the Krukenberg type is an expression of a concomitant degenerative condition of the eye in which glaucoma is likely to supervene, but he found no definite evidence that the pigment deposition alone was producing the glaucoma.

5. As a point of practical value, the author has produced evidence that the water-drinking provocative test performed in young myopic males who have corneal pigmentation of the Krukenberg type will occasionally lead to the early diagnosis of simple glaucoma.

Bortholomew, R. H.; Colvin, E. D.; Grimes, William H.; Fish, John S. and Lester, William M. Department of Ob and Gyn, Emory University School of Medicine. The Mechanisms of Bleeding During Pregnancy. *Am. J. Ob and Gyn* 66:1042-1061 (Nov.) 1953.

Based on an analysis of 1037 cases of bleeding of any amount during pregnancy in 3125 consecutive private patients, the following facts and conclusions were adduced: two thirds of the bleeding occurred in the first trimester (hormonal from blighted ova, marginal sinus rupture and implantation erosion, in order of frequency); the remaining third was divided about equally between second and third trimesters or was manifest in more than one trimester. A sequence of brown to red in increasing amount predominated in the first trimester and usually portended abortion of a blighted product, whereas a sequence of red to brown in decreasing amount was usually compatible with a healthy pregnancy and was usually due to rupture of the developing marginal sinus. The residue of early sinus bleeding apparently produced placenta marginata and circumvallata.

Marginal sinus rupture was responsible for most of the bleeding in the second and third trimesters. The lower the placental implantation site, the greater the likelihood of rupture of the sinus due to stretch of its fragile membranous wall and attachment. In total placenta previa, the stretch is applied to the placenta, the maternal blood descending into the pressureless previa area over the cervix.

The hemorrhage of abruptio is apparently biochemical in origin, placental necrosis releasing excess thromboplastin which initiates clot formation beneath the placenta, causing separation. It is apparently a hemorrhagic phenomenon of toxemia rather than convulsive. Lack of space precludes further details of this mechanism.

Finkle, Alex L., Delofield Hospital Division, Urology, Columbia-Presbyterian Medical Center, New York 32, New York (formerly of Savannah). Surgical Repair of Denuded Penis and Scrotum. *Sou. Med. J.* 46:1092-1099 (Nov.) 1953.

Concomitant avulsions of skin of both the penis and scrotum are uncommon; only 12 such instances had been reported up to 1950. Industrial accidents are nowadays producing such genital denudation more frequently. Three cases of partial denudation of the genitalia, one surgical and two spontaneous—all of post-infection origin—comprise the present report.

Principles of plastic surgical repair of penile and scrotal integumental loss are reviewed, making note of key anatomical, physiological and psychological features. Prompt repair is indicated and is most always possible. Scrotal tags have remarkable regenerative power and should be preserved and utilized. Thermo-regulatory function of the scrotum probably cannot be achieved by any form of surgically constructed substitute. Subcutaneous implantation of denuded tests into each anteromedial thigh should be arranged with regard for comfort and freedom of leg motion.

Split-thickness dermatone grafts from relatively hairless donor-sites effectively re-cover the denuded penis; deletion of dressings seems useful. Formation of skin flaps from each thigh, by a method illustrated in this report, bears promise of good cosmetic and supportive result.

Fitzhugh, Francis W. Jr.; McWhorter, Robert L. Jr.; Estes, E. Horvey Jr.; Worren, Jas. V. and Merrill Arthur J., Renol Laboratory, Department of Medicine, Emory University School of Medicine, Atlanta. The effect of Application of Tourniquets to the Legs on Cardiac Output and Renal Function in Normal Human Subjects. *J. Clin. Investigation* 32:1163-1170 (Nov.) 1953.

1. The application of venous tourniquets to the thighs results in a slight but significant fall in cardiac output; highly significant falls in effective renal plasma flow, urine flow and sodium excretion, and a fall in glomerular filtration rate of borderline significance toward the end of the tourniquet period. With release of the tourniquets all of the above measured functions return to normal. The renal changes occur at different rates; urine flow slowly, sodium excretion more rapidly and renal plasma flow quite promptly.

2. It is suggested that the decrease in cardiac output is most likely due to diminished effective blood volume and that the diminished cardiac output in turn leads to fall in renal plasma flow (and questionably glomerular filtration rate). The inherent errors in the available methods and the lack of methods for performing rapid successive determinations of cardiac output and renal clearances make it impossible to be certain that decrease in renal plasma flow is a result of decreased cardiac output. However, the observed changes in renal function are similar to those seen in other situations where cardiac output is diminished, i.e. chronic congestive heart failure and shock.

3. The cause of sodium retention is not clear but seems to be due to increased tubular reabsorption.

4. The marked antidiuresis which occurs after tourniquets are applied may be due to increased activity of the neurohypophysis, occurring as the result of diminished effective blood volume.

Foraker, Alvon G., Denhom, Sam W. and Aguilar Celi, Polinestor. Departments of Pathology and Obstetrics and Gynecology, Emory University School of Medicine and Grady Memorial Hos-

Abstracts

pital, Atlanta. Dehydrogenase Activity II. In the Fallopian Tube. *Obstetrics and Gynecology* 2:500-507 (Nov.) 1953.

Dehydrogenases are enzymes intimately associated with cell metabolism, growth and function. Sites of dehydrogenase activity were determined in fallopian tubes from 27 women by incubating fresh tissue blocks in neotetrazolium with succinate. Deposition of formazan granules indicating dehydrogenase activity showed: 1. Marked dehydrogenase activity in tubale epithelium, more or less irrespective of other findings in the tubes, or of the clinical setting. 2. Considerable evidence of dehydrogenase activity in inflammatory cells in various types of salpingitis.

Cholesterol crystals were optically and histochemically identified in two cases of chronic salpingitis.

Frobisher, Mortin and Porsons, Elizabeth I., Department of Bacteriology, University of Georgia, Athens. Further Studies of Tellurite Plating Medio for *Corynebacterium Diphtheriae*. *Am. J. Pub. Health* 43:1441-1442 (Nov.) 1953.

Previous studies of tellurite media for the isolation of *C. diphtheriae* from throat cultures had shown that all formulas containing whole (defibrinated) blood were superior to any medium using serum only. Of the several blood media tested two seemed superior to all others. The present study attempted to determine which of these two was the best. On the basis of about 1160 throat cultures tested the two media under comparison (blood-cystine-tellurite agar and chocolate-tellurite agar) were found to be of equal value. Since one is translucent and blood-red while the other is opaque and brown, personal preference must determine final choice between them. Both are superior media in their field.

Goy, Brit B. Jr., Leigh, Ted F. and Rogers, Jos. V. Jr., Department of Radiology, Emory University Hospital, Atlanta. Abdominal Aneurysms as an Uncommon Cause of Duodenal Loop Widening. *Radiology* 61:630-632 (Oct.) 1953.

Widening of the duodenal loop is a well recognized sign in pancreatic disease. It is also present in association with masses of other types in the region of the head of the pancreas. Abdominal aortic aneurysm may cause duodenal loop widening, and simulate very closely a pancreatic lesion. Three such cases are reported by the authors. Clinically, differentiation of pancreatic carcinoma, pancreatic cyst, and abdominal aortic aneurysm is frequently difficult on the basis of physical signs. Palpable pulsations may be absent in aortic aneurysms, and transmitted pulsations from a normal aorta through a pancreatic mass may simulate aneurysm.

Radiologic examinations in most cases will permit differentiation of vascular and non vascular lesions in the region of the head of the pancreas. Routine abdominal roentgenograms will show the presence of a soft tissue mass with curvilinear peripheral calcifications and occasional vertebral erosion, and will allow a diagnosis of aneurysm in most cases. Vascular lesions can be definitely excluded by aortography. The duodenal loop is apparently not frequently affected by aneurysm. Aneurysm of the abdominal aorta should be considered in the differential diagnosis of masses in the region of the head of the pancreas.

Guilfoil, Poul H., Veterans Administration Hospital, Atlanta. Surgical Therapy for Pulmonary Coccidioidomycosis. *Am. Surg.* 19:975-980 (Oct.) 1953.

Three cases of pulmonary coccidioidomycosis treated by resectional surgery are presented. In one case the indication for operation was repeated hemoptysis; in the other two cases it was felt that definitive surgery was required to establish a diagnosis. Indications for surgery are mentioned, as is the fact that surgery does not entail fear of dissemination of disease. It is stressed that a pulmonary lesion plus a positive skin test does not necessarily establish a diagnosis of coccidioidomycosis.

McCain, J. R., Anderson, C. L., Lester, W. M., and Pilkington, J. W., 384 Peachtree St., Atlanta 3, Ga. (McCoin). Prolonged Labor. *JAMA* 153:695-699 (Oct. 24) 1953.

A study is made of the 158 patients whose labors lasted over thirty hours among 19,000 deliveries at Grady Memorial Hospital. It was found that 33 of the infants did not live.

The principle cause for the prolonged labors was uterine inertia. The multiparas with a prolonged labor usually had the ineffective uterine contractions associated with a fetopelvic disproportion.

Progress toward delivery was found to stop within the first twenty-four hours of labor in 75 per cent of the cases. If the progress stopped with the forewaters ruptured and before the baby had begun to descend into the pelvis, over half of the infants died. The two conditions which seemed to be the precipitating causes for the death of the infant were intra partum fever and/or the use of an operative procedure for delivery.

Pregnancies after the one which was prolonged occurred in 77 women. These patients had 101 later deliveries. Ineffective uterine contractions did not become in any of these later labors.

Mirone, Leonoro and Wode, Esther, Department of Nutrition, University of Georgia, Athens. Vitamin B₁₂ and Cobalt Chloride in Growth and Reproduction of Four Strains of Mice. *Am. J. Physiol.* 175:11-12 (Oct.) 1953.

In the first experiment 4 lots of weanling mice were fed stock, basal diet (M), basal diet plus 50 mg. of vitamin B₁₂ per kg. (M^s) and basal diet plus 58 gm. cobalt chloride per kg. (M^a). The weanlings were weighed 3 times per week during growth. At 90 days of age they were bred to fertile males.

In the second experiment 3 lots of adult females, 90 days of age, which had been maintained on stock since weaning were fed stock, diet M and diet M^s respectively. The following day they were bred to fertile males. In both experiments four strains of mice were used, namely: C₃H, C₅₇, CF₁ and dba.

Statistical analysis of the data disclosed that the addition of vitamin B₁₂ and cobalt chloride had no significant beneficial effect on the growth and reproductive performance of the mice. However, there was a significant difference among strains. The average daily gain of the C₃H strain was greater and the offspring at birth were heavier than those of the other 3 strains. Also the number of young weaned in experiment 2 was greater than in experiment 1. Doubtless, the difference was due to the fact that experiment 2 animals had been fed a natural diet up to the time of mating.

* Present address is Berry College, Mt. Berry, Georgia.

Sheo, Patrick C. Jr. and Harrison, J. Harold, from the Whitehead Department of Surgery, Emory University and the Grady Memorial Hospital, Atlanta. Anastomosis of Common and Internal Carotid Arteries. Following Resection of Defective Portion: Report of a Case. *Surgery* 34:895-901 (Nov.) 1953.

Because interruption of carotid circulation is accompanied by a high morbidity and mortality rate, re-establishment of arterial continuity should be considered whenever trauma, carotid body tumors, aneurysms, arteriovenous fistulas, or invasive carcinomas require partial resection of this vessel.

The authors report a successful case of end-to-end anastomosis of the internal and common carotid arteries effected after excision of 3.3 cm. of the carotid artery at the bulb. The vessel was moderately sclerotic. To overcome inherent limitations of operative space, the carotid artery was exposed from the base of the skull to approximately two inches above the clavicle and its branches were freed to allow longitudinal lengthening of the vessels.

The patient's head and neck were not immobilized following the operation. Postoperative use of anticoagulants was not feasible in this case because of the freely bleeding oral surface of a tumor, which was later removed. Nevertheless, a patent anastomosis was obtained and the patient's transient hemiplegia was resolved except for persistent, intrinsic weakness in the muscles of the left hand. Only one similar case has appeared in the literature of the past thirty-nine years, but two additional instances of re-anastomosis of the common and internal carotid arteries are known to the authors.

Thigpen, F. B., Thigpen, C. H. and Cleckley, H. M., Department of Neuropsychiatry, University Hospital, Medical College of Georgia, Augusta. Use of Electric-Convulsive Therapy in Morphine, Meperidine, and Related Alkaloid Addictions. *A.M.A. Arch. Neurol. and Psychiat.* 70:452-458 (Oct.) 1953.

Abstracts

Electric convulsive therapy has occasionally been mentioned in the literature as a valuable method of treating withdrawal symptoms in cases of drug addiction. In our experience with this measure we have found it uniformly effective. Recently, opinions have been expressed that statistical evidence has not been presented to justify this method. We present 34 cases in the hope that others may use a treatment we have found safe and valuable. It is our opinion that additional studies should be made until ample statistical evidence is available to evaluate electric convulsive therapy as a means of alleviating withdrawal symptoms.

Greenblott, Robert B., Department of Endocrinology, Medical College of Georgia, Augusta. Habitual Abortion: Possible Role of Vitamin P in Therapy. *OB & GYN* 2:530-534 (Nov.) 1953.

Another factor is suggested to add to the multitude of causes for habitual abortion, and this is increased capillary fragility, possibly caused by vitamin P deficiency.

In a goodly number of patients who had aborted twice and more times, in whom a positive petechial test was obtained, excellent results followed when hesperidin and vitamin C were added to the regimen of therapy. A percentage of 87.6 of those who had aborted twice carried to term successfully, and a percentage of 57.4 of those who had aborted three times or more, carried to term and delivered living infants.

In addition to hesperidin with vitamin C, our regimen of therapy for the habitual aborter included bed rest, thyroid medication, polyvitamins, and estrogen and progesterone therapy.

It is suggested that correction of abnormal capillary fragility decreases the possibility of retroplacental hemorrhage, or enhances the efficacy of established regimens by modifying capillary permeability and vascular disturbances throughout the body, whether they be in the skin, liver or placenta.

Merrill, Arthur J., Department of Medicine, Emory University Hospital. Chronic Renal Failure. *American Proctitioner and Digest of Treatment*. 4:679-685 (Oct.) 1953.

1. Much can be done to enable many patients with chronic renal failure to live comfortable, economically, profitable lives for several years.

2. A brief physiologic background is presented.

3. The filtering mechanism of the kidney is tested by the urea clearance or the blood NPN test. Proximal convoluted tubular function is represented by the PSP test or the Tm_{PAH} . Distal tubular function is characterized by the concentration test or by a single specific gravity determination. Situations are cited in which any one of these functions may fail individually and the differential diagnostic value of doing all determinations is pointed out. Patients may have an NPN of over 100 mg. per cent with a 55 per cent PSP excretion in one hour.

4. General treatment consists of (a) Protein intake of 20 Gm. daily. In acidosis, NaCl is omitted and $NaHCO_3$ given to prevent body protein breakdown. (c) Salt intake of 4 to 5 Gm. daily. In acidosis, NaCl is omitted and $NaHCO_3$ given in equivalent amounts. (d) K is given only when obviously deficient and when the urinary output is adequate. (e) Calcium is given intravenously in emergencies, as intestinal absorption is ineffective in most cases. (f) Phosphorus and sulfate-containing foods are omitted and aluminum hydroxide

given to increase phosphorus and sulfate excretion in the stool. (g) All acid salts are omitted. (h) Transfusions are the only effective means of treatment of anemia. Plasma is removed from the administered blood if the patient's blood volume is high. (i) Fluids are forced unless contraindicated.

5. The diagnosis and treatment are considered of (a) salt-losing nephritis; (b) K-losing nephritis; (c) calcium losing problems as renal rickets, tubular insufficiency without glomerular insufficiency and Fanconi's syndrome; (d) chloride retaining nephritis.

Weens, H. Stephen and Johnston, M. Horlon, Emory University School of Medicine, Atlanta. Thoracic Renal Ectopia. *Am. J. Roentgenology* 70:793-796 (Nov.) 1953.

Among the several variants of renal ectopia the thoracic type (high ectopia) may be considered as rare. Though this anomaly has been known from autopsy observations, only a few cases have been recognized during life. This malformation may be discovered radiologically as a thoracic mass adjacent to the postero-medial segment of the diaphragm and readily identified by urographic procedures. The proper recognition of thoracic renal ectopia is of clinical importance in the differential diagnosis of other thoracic lesions such as pulmonary neoplasms, pleural tumors and fluid collections, mediastinal masses, and hernias of other abdominal viscera.

The case of thirty-three year old patient is described, in whom chest roentgenography revealed a rounded retrocardiac mass. This mass measured eight cm. in diameter and appeared adjacent to the left diaphragm. Herniation of the left kidney through the diaphragm was suspected and confirmed by retrograde pyelography.

Love, William G., Jr., and Tillery, Bert. Columbus, Go. *New Treatment for Atelectosis of the Newborn*. *Am. Jnl. of Diseases of Children*. 86:423-425 (Oct.) 1953.

In congenital atelectasis, particularly in the premature, the infant presents a clinical picture of marked costal and sternal retraction with intermittent cyanosis. In this form of atelectasis, when tracheal obstruction is not present, Wilson and Farber ascribed the retraction and persistent atelectasis to the fact that the immature, cartilaginous chest wall did not afford an effective scaffolding to counter the strong diaphragmatic contractions.

A traction-stabilization treatment was utilized for these patients with gratifying results. A small towel clip was used to catch the skin and fascia overlying the lower end of the sternum. The handle of this clip was attached to the top of the incubator through the medium of small rubber bands. Additional clips are used in the skin and fascia over the ribs if necessary to control retraction.

The response is frequently immediate with a striking increase in the effectiveness of inspiration and a rapid clearing of the cyanosis. This traction will hold for a period of 24 to 72 hours. During this time the improved expansion will overcome the cohesion of the moist surfaces of the collapsed alveoli and allow pulmonary inflation. Once this is attained a lesser degree of negative pressure is sufficient to maintain satisfactory aeration.

This method of treatment by sternal traction would appear to offer one distinct advantage over the treatment of atelectasis with mechanical respiration; namely, bronchial dilatation occurs with spontaneous inspiration—it does not occur when respiration is mechanically contrived.

International College of Surgeons

The Southeastern District Meeting of the International College of Surgeons is to be held at West Palm Beach, Florida, in the Pennsylvania Hotel on January 29th and 30th, 1954.

Reservations should be made early by writing The Manager, Pennsylvania Hotel, West Palm Beach, Florida, or Dr. Lloyd J. Netto, Chairman, 416 Comeau Bldg., West Palm Beach, Florida.

A. M. A. CLINICAL MEETING

St. Louis, December 1-4, 1953

THE SEVENTH ANNUAL Clinical Session of the American Medical Association was held in St. Louis during the first week in December with approximately three thousand physicians, including Georgia's two delegates, in attendance. These annual meetings are directed to the general practitioner with about 150 papers on various subjects presented by leading physicians of the country. This is supplemented by scientific exhibits, technical displays, motion pictures and color television. The 3-D x-ray films made their debut at this session.

The session was opened by a public relations program on Monday with Dr. Walter B. Martin, A.M.A. president-elect, giving the key note address. At the luncheon Dr. Leo H. Bartemeier, chairman of the A.M.A. Committee on Mental Health, was the speaker. The public relations programs are designed for the enlightenment of the physicians and to alert them to the value of and need for more civic undertakings.

Dr. James S. McLester of Birmingham, Ala., received the Joseph Goldberger award for his contribution to the field of clinical nutrition.

Dr. Joseph Greenwell, an 80-year-old practitioner of New Haven, Ky., received the annual gold medal and citation awarded to the "General Practitioner of the Year."

The House of Delegates met at 10 a.m. Tuesday. The morning program began with addresses by Dr. James R. Reuling, speaker of the House of Delegates and Dr. Chester Keefer, special assistant to Mrs. Oveta Culp Hobby, U. S. Secretary of the Department of Health, Welfare and Education.

A.M.A. President Edward J. McCormick, in his

talk before the House of Delegates expressed the feelings of the delegates when he stated, "good public opinion cannot be bought. It must be earned through exemplary conduct and genuine service in the public interest. Whatever money the A.M.A. and its constituent societies spend for public education and public relations is wasted *unless individual physicians take wholehearted interest in assuring the success of these ventures.*"

Among the 34 resolutions introduced during the session was a resolution introduced by the delegates from the Medical Association of Georgia lamenting the passing of Dr. Frank Kells Boland, nationally known for his history of anesthesia.

Other Measures were: 1. A resolution reaffirming opposition to the compulsory coverage of physicians under the Old Age and Survivors Insurance provisions of the Social Security Act. This is not insurance, but another tax provision which can be changed at the will of congress; 2. A resolution approving the development of a voluntary pension program as provided by the Jenkins-Keogh bills; 3. A resolution reaffirming previous resolutions in regard to non-service connected disability treatment of veterans in VA Hospitals; 4. A resolution opposing any further extension of the "Doctor Draft" Law beyond the present expiration date of June 30, 1955 and, 5. A resolution requesting the Council on Medical Service to proceed immediately with a special study of the problems of catastrophic coverage and coverage for retired persons.

The next annual interim session will be held in Miami, Fla. in December, 1954. Make your plans to attend this session.

Eustace A. Allen, M.D., Delegate

VA STATE CONFERENCE

Atlanta, December 6, 1953

Appearing on the program at a statewide Conference on Veterans Medical Care, December 6, at the Academy of Medicine, Atlanta, were Hartwell Joiner, conference chairman, and Mark Dougherty and Chris McLoughlin. Attending the meeting were Bernard P. Wolff, T. A. Peterson, A. G. Little, Jr., John W. Turner, Virgil B. Williams, W. M. Gilbert, John L. Chandler, Jr., Samuel F.

Rosen, Robert Norton, George P. Kinnard, C. W. Henderson, Arthur P. Richardson, J. A. Green, Lamont Henry, Eustace Allen, Tom Ross, Milford B. Hatcher, Lester M. Petrie, T. F. Sellers, R. Hugh Wood, J. C. Thoroughman, J. B. Avera, B. L. Shackelford, Herbert Alden, W. J. Cranston, Jack C. Norris, Winston E. Burdine, C. C. Aven and Mr. Milton D. Krueger, MAG executive secretary.

ANNOUNCEMENTS

JANUARY 7: Coffee County Medical Society will meet at 1 p.m. at the Douglas Hospital, Douglas.

JANUARY 7: Fulton County Medical Society will hold its annual banquet at the Atlanta Athletic Club.

JANUARY 7: Habersham-Stephens Medical Society will meet at 7:30 p.m. at the Commercial Hotel, Cornelia.

JANUARY 7: Ware County Medical Society will meet at 7:30 p.m. at the Ware Hotel, Waycross.

JANUARY 8: Randolph-Terrell Medical Society will meet at 8 p.m. at the Patterson Hospital, Cuthbert.

JANUARY 11: Walton County Medical Society will meet at 7:30 p.m. at the VFW Home, Monroe.

JANUARY 11: The DeKalb County Medical Society will meet at 7:30 p.m. at the DeKalb County Health Building, Decatur.

JANUARY 12: Altamaha Medical Society will meet at 8 p.m. at the Appling General Hospital, Baxley.

JANUARY 12: South Georgia Medical Society will meet at 7:30 p.m. at the Country Club, Valdosta.

JANUARY 17: MAG Council Meeting, Rome.

JANUARY 17: MAG Maternal and Infant Welfare Committee Meeting, 1 p.m., Macon.

JANUARY 19: Spalding County Medical Society

will meet at 6:45 at the Griffin-Spalding County Hospital, Griffin.

JANUARY 20: Whitfield County Medical Society will meet at 7:30 p.m. at the Hamilton Memorial Hospital, Dalton.

JANUARY 20: Tri-County Medical Society (Calhoun-Early-Miller) will meet at 8 p.m. at Edison.

JANUARY 20: Worth County Medical Society will meet at 8 p.m. at Sylvester.

JANUARY 21: Fulton County Medical Society will meet at 7:30 p.m. at the Academy of Medicine, Atlanta.

JANUARY 21: Richmond County Medical Society will meet at 7:30 p.m. at the Old Medical College Building, Augusta.

JANUARY 21: McDuffie County Medical Society will meet at 8 p.m. at McDuffie County Hospital, Thomson.

JANUARY 25: Gordon County Medical Society will meet at 7:30 p.m. at Calhoun.

JANUARY 26: Polk County Medical Society will meet at 7:30 p.m. at the Wayside Inn, Cedartown.

JANUARY 26: Muscogee County Medical Society will meet at 7:30 p.m. at the Standard Club, Columbus.

JANUARY 26: Walker-Catoosa-Dade Medical Society will meet at 8 p.m. at the Tri-County Hospital, Fort Oglethorpe.

FEBRUARY 1-3: American College of Surgeons, Section Meeting, Charlotte, N. C.

FEBRUARY 3-6: American College of Radiology, Drake Hotel, Chicago.

SOCIETIES

Third District Medical Society met at 2:30 p.m. November 19 at the Americus Country Club, Americus. Speakers were Robert Greenblatt, Harry O'Rear and Lombard Kelly, all of Augusta, and Henry Tift of Macon. The address of welcome was given by Frank Wilson, Leslie, with the response by Hugh Bickerstaff, Columbus. The invocation was given by J. C. Logan, Plains. Officers of the Society are John H. Robinson III, Americus, (on leave of absence for study in New York City) president; Lee Williams, Jr., Cordele, vice president; T. Schley Gatewood, Americus, secretary and W. G. Elliott, Cuthbert, counselor.

Sixth District Medical Society met Wednesday, December 2, in Macon. The Scientific meeting was held in the State Health Building with William Rawlings, Sandersville, president, presiding. Papers, sponsored by the Georgia Heart Association, were read by Bruce Logue, Atlanta, "The Significance of the Systolic Murmur;" Hayward Hill, Atlanta, "The Nature and Course of Aortic Stenosis;" and Robert Ellison, Augusta, "The Surgery of Acquired Valvular Disease." A color film was shown to illustrate the operation of Mitral-Commissurotomy.

Under the heading of new business, C. B. Fulgham, Milledgeville, proposed the name of Dawson Allen, Milledgeville for president of the Medical Association of Georgia. The motion was made by Charles Wasden, Macon, that the Sixth District Medical Society go on record as supporting Dr. Allen's candidacy and this motion was passed unanimously.

New officers of the Society elected at the meeting are George Alexander, Forsyth, president; Charles L. Ridley, Jr., Macon, vice president; C. H. Richardson, Jr., Macon, secretary-treasurer; Dawson Allen, councilor, and H. G. Weaver, Macon, vice councilor. Members to serve on the state committee on Public Policy and Legislation, Henry Tift; state sub-committee on Public Health, W. D. Hazelhurst and committee on Rural Health, J. D. Kay.

The next meeting will be held in April at Milledgeville. The social get-together following the scientific session was held at the American Legion Club Post No. 3 for the members and their wives.

Colquitt County Medical Society met November 12 at the Elks Club, Moultrie. Principal speaker was W. K. Sharpe, Jr., of the State Department of Public Health. His topic was Civil Defense.

Georgia Medical Society met November 23 at the Georgia Medical Society Building. At the meeting, Donald Covalt, Clinical Director of Physical Medicine at New York University, met with the society to discuss the introduction of Physical Medicine and Rehabilitation facilities in Savannah.

PERSONALS

C. C. Aven, Joseph Cruise, Eleanor Petrie, H. C. Schenck, Roy McClain, and Margaret Wall, all of Atlanta, have appeared on radio and television in connection with the Christmas Seal campaign sponsored by the Atlanta Tuberculosis Association.

V. H. Bennett, Gay, was honored recently for his 42 years of profession service to the people of his community. Highlights in Dr. Bennett's life were acted out at the Gay Baptist Church by members of the Gay Civic and Social Co-op Club.

J. R. B. Branch, Brunswick, recently addressed the Brunswick Rotary Club at the Oglethorpe Hotel.

C. T. Brown, Jr., Guyton, was recently elected president of the Emory University alumni club of the Southern Medical Association. *Edgar M. Dunstan*, Atlanta, is retiring president. Other new officers are *Leonard T. Furlow*, St. Louis, Mo., vice president and *C. Dixon Fowler*, Atlanta, secretary-treasurer.

A recent edition of the *Austell Enterprise* carried a story about the modern and well-equipped *Austell Hospital* of which *J. G. Bussey* is owner and administrator. Dr. Bussey is a former resident of McDuffie County.

Hervey M. Cleckley, Augusta, was guest speaker at the recent meeting of the Woman's Auxiliary to the Richmond County Medical Society. Dr. Cleckley traced the development of psychiatry.

Richmond County Medical Society met Thursday, November 19 at the Old Medical College Building on Telfair street in Augusta. Principal speaker was George H. Gehrmann, medical director of the E. I. du Pont de Nemours Co., Inc. of Wilmington, Del. He spoke on broad aspects of industrial medicine with special emphasis on the du Pont Company's industrial relations plan.

Tri-County Medical Society, (Carroll-Douglas-Haralson), met November 4 for a social get-together at the cabin of Dr. and Mrs. W. P. Downey in Tallapoosa. After the buffet barbecue dinner, the doctors and their wives met separately for business sessions.

Troup County Medical Society met recently and the following officers were elected: William B. Fackler, Jr., LaGrange, president; James C. Morgan, Jr., West Point, vice president; William L. Hutchinson, LaGrange, delegate; H. H. Hammett, Jr., LaGrange, alternate delegate. The following were named to the Board of Censors: H. H. Hammett, LaGrange; E. W. Molyneaux, Hogansville and C. M. Whitehead, LaGrange.

Fred J. Coleman, Dublin, has been named chief of staff of the Laurens County Hospital.

Frederick Cooper and *William J. Hamm*, assistant professors of surgery at Emory University, Atlanta, will appear on the program of the Royal College of Surgeons meeting in London May 15 to 17. Dr. Hamm will present a paper on "Cancer of the Skin," and Dr. Cooper will present a paper on "Diseases of the Blood Vessels and Circulatory System."

Ellison R. Cook III, Savannah, recently announced the name of the rehabilitation center at Savannah is to be Rehabilitation Center of Savannah, Inc. Members of the board of directors include *Walter Brown, E. C. Shepherd, W. U. Clary, R. B. Gottschalk, C. F. Holton, T. A. Peterson, Ruth Waring, and T. P. Waring*, all of Savannah.

B. E. Daniel, Claxton, has joined the staff of the Bacon County Hospital at Alma.

Daniel C. Elkin, Atlanta, recently announced establishment of trustees of the Ty Cobb Educational Foundation to aid in college or professional education for young Georgians.

Cleveland W. Findley, Vidalia, and *J. W. Palmer*, Ailey, attended a meeting of the Seaboard Air Line Railroad Surgeons at the Sonora Hotel, St. Petersburg, Fla., Nov. 9-13.

Vernelle Fox, Atlanta, announces the opening of her office for the practice of Internal Medicine at 1299 West Peachtree St., N.E.

F. James Funk, Jr., Atlanta, announces the removal of his office to 1211 West Peachtree St., N.E. Practice limited to orthopedic and traumatic surgery with special interest in pediatric orthopedics.

Luke Garrett, Jr., Austell, was guest speaker at the Lithia Springs PTA meeting recently at the school building. His topic was "The Importance of Teaching Good Health Habits in the Home."

Charles W. Hock and *David R. Thomas*, both of Augusta, are conducting a Postgraduate Course in Gastro Enterology sponsored by the Association of General Practitioners of the Columbia Medical Society. The course which began in November will run through February 3, 1954.

Appearing on the program of a one-day institute sponsored by the Bruce Wilder Muscular Dystrophy Chapter and the Practical Nurses Association of City Hospital, Columbus, were *Jack C. Hughston*, *A. J. Kravtin*, *Dave Berman*, and *Margaret Peeples*, all of Columbus.

John C. Ivey, Atlanta, announces the removal of his office to 739 West Peachtree St., N.E., Lower Floor, Suite "A".

Jack W. Jones, Atlanta, announces his temporary retirement from the practice of dermatology in Atlanta for a period from six to 12 months beginning October 1, 1953 on account of ill health.

Joe W. Kurtz, Atlanta, announces the removal of his office to suite 303, West Peachtree Doctors Building, 663 West Peachtree St., N.E. Practice limited to orthopedic surgery—fractures.

Robert E. Lane, Atlanta, announces the opening of his office at 704 Piedmont Ave., Atlanta. Practice limited to obstetrics and gynecology.

H. G. Lee, Millen, chairman of the Jenkins County Board of Health, recently addressed the Jenkins County unit of the American Red Cross.

Clyde McGeary, Jr., Madison, announces the opening of his office in the McGeary Hospital for the practice of surgery and medicine. Dr. McGeary will be associated with his father, *W. C. McGeary, Sr.*.

Floyd McRae, Atlanta, recently attended the Sowega Sports Car Races at Turner Air Force Base, Albany.

John C. Howard, Athens, announces the opening of his office in The Medical Center on Prince Avenue, Athens for the practice of eye, ear, nose and throat medicine. He will be associated with *T. O. Meissner* and *A. Paul Keller, Jr.*, both of Athens. Dr. Howard is a native of Savannah where his father, *Lee Howard*, and brother, *Lee Howard, Jr.*, are both practicing physicians.

Q. A. Mulkey, Millen, was recently named a member of the State Board of Examiners.

G. T. Olmstead, Jr., Savannah, announces the opening of offices for the general practice of medicine at Springfield. His office will be on the Clyo Road at the edge of town.

G. M. Patillo, Austell, is now associated with *L. G. Garrett, Jr.* in the practice of medicine in Austell.

James W. Pilcher, Louisville, who recently suffered a heart attack, is reported to be improving.

Edgar R. Pund, Augusta, was recently formally inducted as president of the Medical College of Georgia. Also appearing on the program of the induction exercises were *Cleveland Thompson*, *Virgil P. Sydenstricker*, *Robert C. Major*, *J. Dewey Gray*, *A. Bleakley Chandler*, and *W. E. Hamilton, Jr.* all of Augusta.

A. W. Rehberg, Cairo physician, recently addressed the Camilla Rotary Club.

James S. Reynolds, Atlanta, announces the opening of his office at 553 Mobile Ave., S.W., Atlanta, for the general practice of medicine.

C. H. Richardson, Jr., Macon, recently addressed the Woman's Auxiliary to the Bibb County Medical Society. His topic was civil defense.

O. W. Roberts, Sr., Carrollton, recently was named chief of staff of Tanner Memorial Hospital. Other members of the staff are *E. V. Patrick*, vice chief; *H. L. Barker*, retiring chief; *Tom Reeve*, retiring vice chief and *Roy Denney*, secretary-treasurer.

Oscar Leslie Rogers, Sandersville, retired recently after 23 years as health commissioner in the county. Dr. Rogers is 79 years old.

Fred Simonton, Chickamauga, *S. B. Kitchens*, LaFayette and *Frank L. O'Connor*, Rossville, were cited recently for their work on the committee that they secured the Tri-County Hospital at Fort Oglethorpe.

J. L. Shepherd, formerly of Phoenix City, Ala., announces the opening of offices in Omega in the J. E. Winstead building.

H. Scott Titshaw, Gainesville, recently wrote about a tour of Telfair County in the *Telfair Enterprise*.

Perry P. Volpitto, Augusta, will be one of the guest speakers at the New Orleans Graduate Medical Assembly.

Bithel Wall, Augusta, announces the opening of offices for the practice of urology at 1143 Druid Park Avenue.

Charles Watt, Thomasville, is the newly elected president of the Georgia Chapter, American College of Surgeons. Other new officers are *Julian Quattlebaum*, Savannah, vice president; *William G. Whitaker*, Atlanta, secretary and *Joe Reed*, Atlanta, treasurer.

S. S. Youmans, Swainsboro, has recently been named chief of staff of the Emanuel County hospital. He succeeds *C. E. Powell*, Swainsboro.

DEATHS

BUTLER: Clarence G., 60, Gainesville, died November 30. A native of Danville, Dr. Butler lived 28 years in Gainesville. He was educated at Gordon Military Academy, the University of Georgia, and the Medical College of Georgia. He was senior

warden of Grace Episcopal Church in Gainesville and served on the board of directors of the First Federal Loan Company.

TIMMONS: Carl Conrad, 64, Augusta, died November 9 at an Augusta hospital. A native of Early County, Dr. Timmons was graduated from Emory University and the Medical College of Georgia. He served at one time as Richmond County physician. He was a member of the Webb Masonic Lodge and was a 32nd degree Scottish Rite Mason and Shriner.

Georgia A.M.E.F. Fund

The following physicians, listed by county medical society, have contributed to the American Medical Education Foundation in October and November, 1953. Those making their contribution direct to the AMEF Headquarters may not be listed unless official notification has been received therefrom.

Chatham County

John L. Elliott, Savannah

Cherokee-Pickens

C. J. Roper, Jasper

E. A. Roper, Jasper

Clark County

H. G. Byrd, Athens

Floyd County

Warren M. Gilbert, Rome

Fulton County

Charles Eberhart, Atlanta

Polk County

C. B. Elliott, Cedartown

Telfair County

F. R. Mann, Jr., McRae

Thomas County

J. J. Collins, Thomasville

Ware County

W. C. Calhoun, Waycross

W. H. Pomeroy, Waycross

Leo Smith, Waycross

Neal F. Yeomans, Waycross

To: The Medical Association of Georgia
875 West Peachtree Stree, N. E.
Atlanta, Georgia

amef AMERICAN
MEDICAL
EDUCATION
FOUNDATION

1. I wish to contribute \$_____to the A.M.E.F.
and further wish to designate this amount to_____University.

2. I desire to pledge \$_____annually to the Foundation and further wish to designate this
amount to_____University.

My check for contribution is enclosed (*payable to the A.M.E.F.*)

NAME:_____

STREET ADDRESS_____

CITY_____

County Medical Society_____

ROSTER of MEMBERSHIP

December 31, 1953

This roster is made up of physicians whose names have been forwarded the Headquarters office by the secretaries of the component county societies and whose dues have been paid as of December 31, 1953. Also included are the names of those physicians who have been classified as Associate, Life and Scientific members. For any omissions, check with the county society secretary.

This official roster of members will

be used as a basis of determination of the number of delegates and alternates to serve in the House of Delegates at the Annual Session to be held in Macon, May 2-5. (One delegate for each 25 members or fraction thereof.)

Members of county societies having less than three members are listed temporarily as Members at Large, until they have been accepted by an adjacent county society.

ALTAMAHA MEDICAL SOCIETY APPLING COUNTY

Bedingfield, James Andrew, Baxley
Branch, W. D., Baxley
Brown, Jesse Bryan, Jr., Baxley
Holt, J. T., Baxley
Kennedy, F. D., Baxley
McCrackin, H. C., Baxley
Ohlmacher, Albert Philip, Brunswick
Virusky, Edmond Joseph, Baxley

BALDWIN COUNTY

Allen, E. W., Milledgeville
Allen, H. D., Jr., Milledgeville
Baugh, James Emory, Milledgeville
Binion, Richard (deceased), Milledgeville
Bowen, U. S., VA Center, Wilshire and
Sawtelle Boulevards, Los Angeles 25,
California
Bradford, R. W., Milledgeville
Browne, Thomas Morgan, Ga. Training
School for Boys, Milledgeville
Cary, H. R., Milledgeville
Chestnutt, T. H., Milledgeville
Combs, Joe D., Milledgeville
Echols, George L., Milledgeville
Fulghum, C. B., Milledgeville
Gibson, Wallace M., Milledgeville State
Hospital, Milledgeville
Jones, James Richard, Jr., Milledgeville
Jordan, Charles, Eatonton
Peacock, Thomas Gerald, Milledgeville
State Hospital, Milledgeville
Pursley, Norman B., Georgia Training
School, Gracewood
Sanchez, A. S., Eatonton
Scott, Iona D., Milledgeville State Hos-
pital, Milledgeville
Scott, Wilbur Moate, Scott Hospital,
Milledgeville
Smith, M. E., Milledgeville State Hos-
pital, Milledgeville

Smith, W. T., State Hospital, Milledge-
ville
Walker, E. Y., Baldwin Memorial Hos-
pital, Milledgeville
Waller, Robert Drane, Box 44, Mauk
Wiley, John D., Milledgeville
Williams, David C., Milledgeville State
Hospital, Milledgeville
Woods, O. C., Milledgeville
Yarbrough, Y. H. (Life), Milledgeville

BARTOW COUNTY

Bradford, H. B., Cartersville
Dillard, Wm. Barnett, Jr., Cartersville
Horton, A. L., Cartersville
Howell, S. M., Cartersville
Howell, Wm. Harvey, Cartersville
Quillian, Wm. B., Jr., Cartersville
Stanford, J. W., Cartersville
Whatley, Lewis Ross, Cartersville
Wofford, W. E., Cartersville

BEN HILL COUNTY

Coffee, W. P., Fitzgerald
Cornwell, Gibson K., Fitzgerald
Dismuke, H. L., Ocilla
Harper, Aubrey (Life), Wray
Johnson, Roy J., Jr., Fitzgerald
McElroy, S. L. (Life), Ocilla
Roberts, Ralph D., Fitzgerald
Sams, Wm. Christopher, Jr., Ocilla
Smith, J. E., Fitzgerald
Ward, Francis O., Fitzgerald
Ware, D. B., Fitzgerald
Willcox, W. D., Fitzgerald
Willis, G. W., Ocilla

BIBB COUNTY

Aldrich, Fred N., Professional Building,
Macon
Anderson, Carl L. (Assoc.), 556 Mul-
berry Street, Macon
Anderson, J. C., 106 Stanislaus Circle,
Macon

Applewhite, J. D., 700 Spring Street,
Macon
Atkinson, H. C., 700 Spring Street,
Macon
Barnes, Walter P., Jr., 787 Spring Street,
Macon
Barton, William L., Persons Building,
Macon
Baxley, W. W., Persons Building, Macon
Bazemore, W. L., 553 Walnut Street,
Macon
Benton, Charles Crisp, 781 Spring
Street, Macon
Billinghurst, George A., Persons Build-
ing, Macon
Birdsong, William R., 531 North Ave-
nue, Macon
Blum, Leo J., Jr., Warner Robins
Boswell, W. Charles, Persons Building,
Macon
Brannen, Edmund A., 700 Spring Street,
Macon
Brown, Roland A., Medical Arts Build-
ing, Macon
Bush, Walter Holloway, 959 Daisy Park,
Macon
Caldwell, James Leonidas, 781 Spring
Street, Macon
Cary, R. Frank, 845 Hemlock Street,
Macon
Chrisman, W. W., 700 Spring Street,
Macon
Clay, Calder B., Jr., 203 Professional
Building, Macon
Clay, J. Emory, Clinic Hospital, Macon
Cole, Allan A., 654 First Street, Macon
Collins, Braswell E., 959 Daisy Park,
Macon
Corn, Ernest, 700 Spring Street, Macon
Daniel, Joe Wesley, Jr., Bibb Building,
Macon
Davenport, Lowrey Frederick, 700
Spring Street, Macon

* In service.

Dove, W. B. (Life), 1777 Rembert St., Macon
 Davis, W. A., 591 Cotton Avenue, Macon
 DuPree, G. W., Gordon
 DuPree, John T., Professional Building, Macon
 Dyer, C. W., 853 Tattnall Street, Macon
 Eberhardt, Reese C., 3671 Houston Avenue, Macon
 Edenfield, Robert Watts, 700 Spring Street, Macon
 Ewing, Richard C., Professional Building, Macon
 Farmer, C. Hall, 553 Walnut Street, Macon
 Ferrell, R. G., Jr., Professional Building, Macon
 Forester, Beverly Wood, 700 Spring Street, Macon
 Frayser, W. N., Mitchell Building, Macon
 Fry, Elmer Lee* (Assoc.), U. S. Naval Hospital, St. Albans
 Gallemore, John I., Perry
 Goldstein, Josef Jay, Warner Robins
 Golsan, W. R., Persons Building, Macon
 Goodman, Leon J., Bibb Building, Macon
 Goolsby, R. Cullen, Jr., 700 Spring Street, Macon
 Greer, Zack Evans, Bibb County Health Department, Macon
 Hall, John I., 781 Spring Street, Macon
 Hall, T. H. (Life), Grand Building, Macon
 Hanson, J. Fletcher, 3834 The Prado, Macon
 Harrold, Thomas, 700 Spring Street, Macon
 Hatcher, Milford B., 781 Spring Street, Macon
 Hazlehurst, W. Derrell, 765 Spring Street, Macon
 Hicks, Walter Lynn, 3671 Houston Avenue, Macon
 Hogan, Jasper Thomas, Jr., 3828 The Prado, Macon
 Holden, William Hall, 367 New Street, Macon
 Homeyer, Walter F., Jr., 781 Spring Street, Macon
 Hooper, Robert J., 1105 River Road, Greenwood, Mississippi
 Houser, Frank M., Bankers Insurance Building, Macon
 James, L. P., 700 Spring Street, Macon
 Jarrett, W. D., 244 East Pearson Street, Evanston, Illinois
 Johnson, J. F., 1445 Oglethorpe Street, Macon
 Johnston, G. A., 853 Tattnall Street, Macon
 Jones, John P., 865 Hemlock Street, Macon
 Jones, Rudolph Wagner, Jr., 959 Daisy Park, Macon
 Jordan, William K., 700 Spring Street, Macon
 Kay, J. B., Byron
 Keen, O. F., Persons Building, Macon
 King, J. L., Persons Building, Macon
 King, James Lon, Jr., Persons Building, Macon
 Lewis, William Earl, Persons Building, Macon
 Martin, John Owen, 754 Pine Street, Macon
 Mass, Max, Macon Hospital, Macon
 Massenburt, G. Y., The Clinic Hospital, Macon

Mays, J. R. S., 700 Spring Street, Macon
 McAllister, Robert W., 700 Spring Street, Macon
 McFarlane, John W. (deceased), 201 Professional Bldg., Macon
 McLaughlin, C. K., 703 Bankers Building, Macon
 McMichael, V. H., Clinic Hospital, Macon
 McMillan, Eugene C., Jr., 219 Bibb Building, Macon
 Meriwether, W. W., 369 Cotton Avenue, Macon
 Meserve, Francis Bruce, 721 McArthur Boulevard, Warner Robins
 Mobley, W. E. (Assoc.), 563 College Street, Macon
 Nathan, Daniel E., Fort Valley
 Neal, Jule C., Jr., 203 Professional Building, Macon
 Newman, W. A., 700 Spring Street, Macon
 Newton, R. G., Persons Building, Macon
 Olmick, Herbert M., 700 Spring Street, Macon
 Orr, William Wood, 700 Spring Street, Macon
 Patton, Samuel Ellsworth, 797 Poplar Street, Macon
 Phillips, A. M., 1113 Bankers Insurance Bldg., Macon
 Pope, Edgar M., Doctors Building, Macon
 Porch, Leon D., 700 Spring Street, Macon
 Rawls, Lewis L., Persons Building, Macon
 Reifler, R. M., 729 Pine Street, Macon
 Richardson, C. H., Sr., 700 Spring Street, Macon
 Richardson, C. H., Jr., 700 Spring Street, Macon
 Richardson, R. W., 1429 Oglethorpe Street, Macon
 Ridley, Charles Lewis, Sr., Macon Hospital, Macon
 Ridley, Charles Lewis, Jr., Persons Building, Macon
 Rogers, T. E. (Assoc.), 120 Clisby Place, Macon
 Rogers, Thomas Edward, Jr., 700 Spring Street, Macon
 Ross, Thomas L., Jr., 700 Spring Street, Macon
 Rubin, Samuel N., Gordon
 Rumble, Charles T., 700 Spring Street, Macon
 Rutland, S. C., Dept. of Public Health, Atlanta
 Siegel, Alvin E., Medical Arts Building, Macon
 Smith, Horace D., VA Hospital, Long Beach, California
 Smith, J. Allen, 700 Spring Street, Macon
 Smith, R. Stillman, 335 Broadway, Macon
 Stamps, Edward Roe, 617 Bibb Building, Macon
 Stewart, J. Benham, 700 Spring Street, Macon
 Suarez, Raymond, Medical Arts Building, Macon
 Swilling, Evelyn, 553 Walnut Street, Macon
 Thompson, O. R., 700 Spring Street, Macon

Tift, Henry H., 765 Spring Street, Macon
 Vinson, Frank, Fort Valley
 Walker, D. D., 700 Spring Street, Macon
 Walker, Duncan, Jr., 753 Pine Street, Macon
 Ware, Ford, 607 Bankers Building, Macon
 Wasden, C. N., Bankers Building, Macon
 Watson, Edwin R., 553 Walnut Street, Macon
 Weaver, H. G., 700 Spring Street, Macon
 Weems, Horace Eugene, Jr., Perry
 Williams, J. S., Walton Building, Macon
 Williams, W. A., 700 Spring Street, Macon
 Woodhall, Jerry Phillip, 700 Spring Street, Macon
 Work, Samuel D., Jr., 729 Pine Street, Macon
 Zachary, J. D. (Life), Gray

BLUE RIDGE MEDICAL SOCIETY (FANNIN, GILMER, UNION COUNTIES)

Brooks, Courtney C., Blue Ridge
 Burdine, J. M., Burdine Clinic, Ellijay
 Burns, R. A.* (Assoc.), 49 Med. Group, APO c/o PM, San Francisco, Calif.
 Edge, H. M., Blairsville
 Hicks, Thomas J., McCaysville
 May, L. C., Blue Ridge
 O'Daniel, John Y., Ellijay
 Shingleton, Gerald C., Blue Ridge
 Tanner, William F., Young Harris
 Watkins, Edward W. (Life), Ellijay

BROOKS COUNTY

Jones, A. B., Jr., Quitman
 Shealy, L. M., 910 Court Street, Quitman
 Smith, L. A., Quitman
 Thwaite, Walter G., Quitman
 Wasden, Harry A., Quitman

BULLOCH-CANDLER-EVANS COUNTIES

Barksdale, John Henry, Jr., Statesboro
 Daniel, A. B., Statesboro
 Deal, Albert Mulherin, Statesboro
 Deal, Helen Read, Statesboro
 Deal, John Daniel, Portal
 Floyd, W. E., Statesboro
 Griffin, Louie H., Claxton
 Hames, Curtis G., Claxton
 Kennedy, R. L., Metter
 Lovett, K. S., Metter
 Lovett, L. F. (Assoc.), Metter
 McElveen, J. M., Brooklet
 Mooney, John, Jr., Statesboro
 Moore, Ed. L., Statesboro
 Olliff, H. H., Register
 Neville, J. C. (deceased), Register
 Patrick, J. Z. (Life), Pulaski
 Simmons, Walter E., Metter
 Stapleton, C. E., Statesboro
 Whiteside, J. H., Statesboro

BURKE COUNTY

Barger, E. A., Waynesboro
 Bent, H. F., Midville
 Butterfield, Donald L., Waynesboro
 Byne, J. M., Jr., Waynesboro
 Cantrell, James E., 1501 7th Street, Albany
 Green, Charles G., Waynesboro
 Hillis, W. W., Sardis
 McCarver, W. C., Vidette
 Thompson, Cleveland, Waynesboro
 Thompson, Cleveland, Jr., Waynesboro

**CARROLL-DOUGLAS-HARALSON
COUNTIES**

Aderhold, W. A. (Life), Carrollton
Allen, C. H., Bremen
Astin, Phil Carroll, Jr., 13 West Chandler Street, Carrollton
Bagley, D. A. (Assoc.), Austell
Barker, H. L., Carrollton
Bass, Eldred C., Carrollton
Berry, Robert L., Villa Rica
Cauthen, Larry Rupert (Assoc.), 21 John Ross Road, Chattanooga, Tennessee
Denney, Roy Lumpkin, Carrollton
Downey, Wm. P., Tallapoosa
Eaves, B. F. (deceased), Draketon
Hamilton, R. E., Douglasville
Hogue, W. L. (Life), Villa Rica
Holtz, Louis, P.O. Box 265, Carrollton
King, O. D., Bremen
Martin, Talmadge M., Jr., Bowdon
Morgan, F. W., Douglasville
Nutt, J. J., Bowdon
Parks, Francis Meredith, 144 Dixie Street, Carrollton
Patrick, Elwyn Vincent, Carrollton
Powell, B. C. (Life), Villa Rica
Powell, John E., Jr., Villa Rica
Powell, John E., Villa Rica
Pritchett, John Henry, Jr., Bremen
Reese, D. S. (Life), Carrollton
Reeve, Thomas Ellis, Jr., Carrollton
Roberts, O. W., Carrollton
Smith, W. P. (Life), Bowdon
Taylor, T. B., Douglasville
Thomas, S. D., Carrollton
Thomasson, W. E., Carrollton
Vansant, C. V., Douglasville
Watts, J. W., Bowdon
Wilson, L. E. (Life), Bowdon
Word, J. J., Tallapoosa
Worthy, W. Steve, Carrollton

**GEORGIA MEDICAL SOCIETY
(CHATHAM COUNTY)**

Alexander, James Leonidas, 104 East Gwinnett Street, Savannah
Barfield, William Edward, 722 Drayton Street, Savannah
Bedingfield, W. O., 14 West Hull Street, Savannah
Bodziner, L. S., 126 East Gaston St., Savannah
Bowdon, Ralph O., 24 West Gaston Street, Savannah
Brawner, Darnell LaVern, 513 Whitaker Street, Savannah
Broderick, J. R., 125 East Jones Street, Savannah
Brown, C. T., Guyton
Brown, F. B., 22 West Gaston Street, Savannah
Bush, H. J., DeRenne Apartments, Savannah
Center, Abraham H., 17-A West Gordon Street, Savannah
Charlton, T. J. (Assoc.), 220 East Oglethorpe Street, Savannah
Chisholm, J. F. (Life), 512 Abercorn Street, Savannah
Cirincione, Vincent John, 1 West Duffl Street, Savannah
Clary, W. U., 228 East Huntingdon Street, Savannah
Cole, W. A. (Life), 32 East Taylor Street, Savannah
Cook, E. R., 513 Whitaker Street, Savannah
Coward, Allen W., 17 East Jones Street, Savannah
Crawford, W. Barron, Jr., 14 East Taylor Street, Savannah

Dancy, W. R. (Assoc.), 102 West Jones Street, Savannah
Daniel, John William (Life), (Deceased), 26 East 31st Street, Savannah
DeCaradeuc, St. J. R. (Life), DeRenne Apartments, Savannah
Drane, Robert, DeRenne Apartments, Savannah
Duncan, J. Harry, 116 East Jones Street, Savannah
Dunn, L. B., 220 East Huntingdon Street, Savannah
Edwards, D. B. (Assoc.), Ellabel
Edwards, Ernest Goodall, 3½ East Gordon Street, Savannah
Egan, M. J., 210 East Liberty Street, Savannah
Epting, M. J., 722 Drayton Street, Savannah
Faggart, G. H., 18 West Oglethorpe Avenue, Savannah
Fillingim, D. B., 449 Abercorn Street, Savannah
Frech, Henry C., Jr., 427 Bull Street, Savannah
Freedman, L. M., 1½ East Gordon Street, Savannah
Freeman, Thomas R., 513 Whitaker Street, Savannah
Fulmer, William Henry, 19 East 34th Street, Savannah
Gleaton, E. N., 2 East Jones Street, Savannah
Goldenstar, Grant Wilbur, 106 East Jones Street, Savannah
Gottschalk, Robert Bruce, 123 East Jones Street, Savannah
Graham, Rufus E. (Life), 212 East Gaston Street, Savannah
Ham, Oscar Emerson, 414 Bull Street, Savannah
Henderson, Clair A., Health Department, Savannah
Holton, Cornelius Fulmer, DeRenne Apartments, Savannah
Hopkins, Anne, 22 East Jones Street, Savannah
Howard, Lee, Jr., DeRenne Apartments, Savannah
Howkins, John, 111 East Jonest Street, Savannah
Johnson, G. Hugo, Jr., 126 East Oglethorpe Avenue, Savannah
Jones, Jabez (Life), 11 West Gordon Street, Savannah
Kandel, H. M. (Deceased), 432 Abercorn Street, Savannah
Kanter, W. W., 345 Bull Street, Savannah
Kelley, Albert J., 4 Taylor Street, East, Savannah
King, Ruskin, 10 West Taylor Street, Savannah
Lang, G. H. (Life), 202 East Liberty Street, Savannah
Lange, Stephen J., 12 East Taylor Street, Savannah
Lawless, Thomas F., 204 East Liberty Street, Savannah
Lee, Lawrence, Jr., 113 East Gwinett Street, Savannah
Levington, H. L., 209 East Gaston Street, Savannah
Lippitt, William Henry, 224 East Huntingdon Street, Savannah
Long, W. V., Hotel DeSoto, Savannah
Lott, Oscar H., 111 East Jones Street, Savannah
Lynn, S. C., 124 East Jones Street, Savannah
Maner, E. N. (Assoc.), 101 East 45th

Street, Savannah
Marsh, P. R., DeRenne Apartments, Savannah
Martin, R. V. (Life), 18 East 31st Street, Savannah
Mazo, Milton M., 8 East Taylor Street, Savannah
McGoldrick, Thomas Aloysius, Jr., 15 East Gordon Street, Savannah
Metts, James C., 110 West Gaston Street, Savannah
Morrison, Howard J., 444 Drayton Street, Savannah
Nichols, Fenwick T., Jr., 123 East 51st Street, Savannah
Oliver, R. L., DeRenne Apartments, Savannah
Olmstead, G. T. (Life), 20 East Taylor Street, Savannah
Ortega, Paul, Jr. (Assoc.), U.S. Communicable Disease Center, Oatland Island, Savannah
Osborne, Elton Smith (Life), 19 East Jones Street, Savannah
Osborne, William Wilson, 631 Washington Avenue, Savannah
Osteen, W. L., 610 Anderson Avenue, Savannah
Otto, Walter W., 23 East Charlton Street, Savannah
Pacifici, Joseph, 2 East Taylor Street, Savannah
Peterson, T. A., 116 East Huntingdon Street, Savannah
Pinholster, J. H., 241 Abercorn Street, Savannah
Porter, J. E., 128 East Taylor Street, Savannah
Portman, Harry J., 9 East Gordon Street, Savannah
Powers, Leander K., 29 East Jones Street, Savannah
Prince, Charles L., 2515 Habersham Street, Savannah
Puckett, Hollis Elwood, 118 East Hall Street, Savannah
Quattlebaum, J. K., 24 West Gaston Street, Savannah
Rabham, L. J., 314 East Gaston Street, Savannah
Rabun, John Brewton, DeRenne Apartments, Savannah
Redmond, C. G. (Life), 701 Whitaker Street, Savannah
Redmond, C. R. A., 530 East 49th Street, Savannah
Righton, H. Y. (Life), 101 East Waldburg Street, Savannah
Robinson, David, P. O. Box 394, Savannah
Rosen, E. F., 5 East Gordon Street, Savannah
Rosen, Samuel F., 4 East Jones Street, Savannah
Rubin, Jacob, 350 Bull Street, Savannah
Salter, William Lawrence, 2427 Abercorn Street, Savannah
Sax, Charles E., 214 East Gaston Street, Savannah
Scardino, Peter Lester, 2515 Habersham Street, Savannah
Schley, Richard Larcombe, Jr., 114 Gaston Street, Savannah
Schneider, M. M., 126 Gaston Street, East, Savannah
Sharpley, Helen, 109 East Jones Street, Savannah
Sharpley, H. F., Jr., DeRenne Apartments, Savannah
Sharpley, John G., DeRenne Apartments, Savannah

Shearouse, J. William, 14 East Taylor Street, Savannah
 Shepherd, Edwin C., 12½ West Taylor Street, Savannah
 Smith, Harold M., 9 West Gordon Street, Savannah
 Smith, P. H., 3 East Gordon Street, Savannah
 Stalvey, John Kelly, Jr., 114 East Jones Street, Savannah
 Straight, George William, 202 East Gordon Street, Savannah
 Taylor, Lloyd B. (Life), 107 West Huntingdon Street, Savannah
 Train, J. K., Jr., 1107 Bull Street, Savannah
 Train, J. K. (Assoc.), 1107 Bull Street, Savannah
 Upson, E. T., 201 East Hall Street, Savannah
 Usher, Charles (Life), 6 East Liberty Street, Savannah
 Victor, Irving, 228 East Huntingdon Street, Savannah
 Victor, Jules, Jr., 126 East Taylor Street, Savannah
 Waring, Antonio Johnston, Jr., DeRenne Apartments, Savannah
 Waring, Ruth Moyer, 905 East Duffy Street, Savannah
 Waring, Thomas Pickney, 905 Duffy Street, Savannah
 Westerfield, Charles W., 101 Garrard Avenue, Goidonston, Savannah
 Whelan, E. J. (deceased), 14 West Jones Street, Savannah
 Williams, A. F., 127 East Gordon Street, Savannah
 Williams, L. W., 105 East Jones Street, Savannah
 Wilson, W. D., 104 West Waldberg Street, Savannah
 Winburn, James Randall, Jr., DeRenne Apartments, Savannah
 Withington, John Cummings, 106 West Jones Street, Savannah
 Youngblood, Samuel, Jr., 108 East Taylor Street, Savannah
 Zigler, Isaac S. (Assoc.), U. S. Public Health Service Hospital, Savannah
 Zirkle, John Gordon, 722 Drayton Street, Savannah

CHATTOOGA COUNTY

Allen, John Joseph, Trion
 Gist, William Thomas, 23 Commerce Street, Summerville
 Goodwin, Hugh Alexander, Jr., Summerville
 Hyden, William U., Trion
 Little, G. H., Trion
 Little, R. N., Summerville
 Martin, William Porter, Box 195, Summerville

CHEROKEE-PICKENS COUNTIES

Andrews, Charles R., Jr., Canton
 Boswell, T. C., Tate
 Coker, Grady N., Canton
 Glover, O. G., Jr. * (Assoc.), Canton (U.S.A.)
 Hendrix, Arthur M., Canton
 Hendrix, Gordon (Life), Ball Ground
 Jones, Robert T., III, Canton
 Looper, Ben Keith, Cherokee Clinic, Canton
 Moore, R. M. (Life), Waleska
 Nichols, W. H., Canton
 Perrow, Guerrant Heath, Jasper
 Roper, C. J., Jasper
 Roper, E. A., Jasper

Vansant, T. J. (Life), Woodstock

CLARKE-MADISON-OCONEE COUNTIES

Barner, John L., Athens General Hospital, Athens
 Bond, D. T., Danielsville
 Bonner, William H., 130 West Hancock Avenue, Athens
 Boyd, Augustus Brown, Athens General Hospital, Athens
 Brown, W. W., City Health Department, Athens
 Bryant, C. H., Comer
 Byrd, H. G., 223½ College Avenue, Athens
 Cabaniss, W. H., Southern Mutual Building, Athens
 Dover, Tom A., 1010 Prince Avenue, Athens
 Elder, John D., 364 Parkway Drive, Athens
 Erwin, Goodloe Yancey, 130 West Hancock Avenue, Athens
 Florence, Loree, Southern Mutual Building, Athens
 Gallis, Anthony H., Georgian Hotel, Athens
 Gerdine, Linton,* c/o Fleet Post Office, San Francisco, Calif.
 Goldsmith, Lauren H., 390 N. Milledge Avenue, Athens
 Green, James A., 1010 Prince Avenue, Athens
 Gustin, Ronald M., 530 Holman Avenue, Athens
 Harris, H. B., Southern Mutual Building, Athens
 Harrison, W. B., State Health Department, Athens
 Holliday, Henry C., Athens
 Hubert, M. A., Southern Mutual Building, Athens
 Keller, Alexander Paul, Jr., 1010 Prince Avenue, Athens
 Kitchens, William C., 130 West Hancock Avenue, Athens
 McDonald, James J., 455 N. Milledge Avenue, Athens
 McPherson, John H. T., 468 N. Milledge Avenue, Athens
 Meissner, Tom, 1010 Prince Avenue, Athens
 Middlebrooks, C. O. (Life), Holman Hotel, Athens
 Moss, W. L. (Life), Jefferson Road, Athens
 Neighbors, J. B., Jr., 90 N. Milledge Avenue, Athens
 Patton, L. S. (deceased), Southern Mutual Building, Athens
 Randolph, Rivington H., 130 W. Hancock Avenue, Athens
 Simpson, John A., Southern Mutual Building, Athens
 Stegeman, John Foster, 130 W. Hancock Avenue, Athens
 Talmadge, Harry E., Southern Mutual Building, Athens
 Traylor, James Bothwell, 455 N. Milledge Avenue, Athens
 Veale, Emory O. (deceased), Arnolds-ville
 Warga, P. W., Athens General Hospital, Athens
 Westbrook, E. J. (Life), Ila
 Whitley, L. L., 234 College Avenue, Athens

CLAYTON-FAYETTE COUNTIES
 Busey, T. J., Fayetteville

Coleman, Y. R. (deceased), Jonesboro
 Sams, Ferrol Aubrey, Jr., Fayetteville
 Sams, Helen Fletcher, Fayetteville
 Thornton, Hollister Alvin, Jr., P. O. Box 236, Jonesboro
 Wallis, J. R., Lovejoy

COBB COUNTY

Bannister, Clifford D., Marietta
 Benson, Wm. H., Jr., 213 Cherokee Street, Marietta
 Burleigh, Bruce D., 515 Clay Street, Marietta
 Bussey, J. G., Austell
 Butner, John Hendrick, Powder Springs
 Cauble, George, Acworth
 Clark, F. B., Austell
 Clark, Remer Young, Jr., 206 Roswell Street, Marietta
 Clonts, W. T., Marietta
 Colquitt, Alfred O., Jr., 215 Cherokee Street, Marietta
 Colquitt, Hugh S., Smyrna
 Crawley, Walter G., 1505 Roswell Street, Marietta
 Fowler, A. H., Marietta Hospital Building, Marietta
 Fowler, R. W., Marietta Hospital Building, Marietta
 Garland, Charles Mayo, Jr., Smyrna
 Garrett, Luke G., Jr., Austell
 Gober, W. Mayes, 304 Cherokee Street, Marietta
 Hagood, George Felton, 204 Cherokee Street, Marietta
 Hagood, M. M., Marietta Hospital Building, Marietta
 Inglis, Ervine Peter, Jr., 210 Cherokee Street, Marietta
 Jennings, C. M., Marietta
 Lester, J. E., 208 S. Waddell Street, Marietta
 Levy, M. S., Smyrna
 Lindley, F. P. (deceased), Powder Springs
 Marks, Edward Schaefer, 261½ North Park Square, Marietta
 Mathis, W. H., Jr., Marietta
 McCall, Moses Nathaniel, Jr., Acworth
 Meaders, Henry DeWitt, Marietta
 Mitchell, W. C., Smyrna
 Musarra, E. A., Marietta
 Perkinson, W. H., Marietta Hospital Building, Marietta
 Roberts, Jessie Morris, 1242½ Greene Street, Augusta
 Roberts, J. A., 1242½ Green Street, Street, Augusta
 Schmidt, Frederick Kenneth, 206 Roswell Street, Marietta
 Teem, M. V. B., 502 Cherokee Street, Marietta
 Vansant, Thomas Jacob, Jr., 105 Seminole Drive, Marietta
 Weddington, W. H., Marietta

COFFEE COUNTY

Bell, Eugene Demarque, Douglas
 Bush, James L., Douglas
 Clark, T. H. (Assoc.), Douglas
 Duley, Jack R., Nicholes
 Greenberg, H. L., Sylacauga Hospital, Sylacauga, Alabama
 Harper, Sage, Douglas
 Jardine, Dan A., Douglas
 Johnson, R. L., Douglas
 Joiner, Horace G. (Assoc.), Douglas
 Meeks, Calvin Stewart, Jr., Douglas
 Parker, T. L., Douglas
 Quilliam, B. O., Douglas

Shellhouse, L. H., Willacoochee
Wallace, J. W., Douglas

COLQUITT COUNTY

Brannen, Cecil N., Moultrie
Conger, Preston DeWitt, Moultrie
Fike, Rupert Howard, Moultrie
Fokes, Robert E., Jr., Moultrie
Funderburk, A. G., Moultrie
Gay, Frank M., Moultrie
Holmes, Edgar C., Moultrie
Hutchinson, Norton Humphreys (Assoc.), Moultrie
Joiner, R. M., Moultrie
Lanier, J. E. (deceased), Moultrie
McCoy, John Franklin, Moultrie
McGinty, W. R., Moultrie
McLeod, John W., 305 South Main Street, Moultrie
Paulk, J. R., Moultrie
Stegall, Robert E., Moultrie
Stone, Julius C. (Life), Doerun
Whitendale, Wm. H. (Life), Norman Park
Withers, Samuel M., Jr. (Assoc.), 75 Mathews Drive, Columbus
Woodall, J. B., Moultrie

COWETA COUNTY

Arnold, J. H., 35 Jefferson Street, Newnan
Barksdale, C. R., Jr., Grantville
Bryant, James Monroe, Jr., Brown Street, Newnan
Cochran, M. F. (deceased), Newnan
Elliott, Clifford Clay, Sargent
Farmer, Charles W., Jr., 14 West Washington Street, Newnan
Glover, Howard C., Jr., Newnan
Glover, N. B., Newnan
Hammond, George W., Jefferson Street, Newnan
Jackson, Bruce, Route 1, Newnan
Kinnard, George P., Newnan
McDonald, Robert H., Newnan
Parks, Joseph W., Jr., Newnan
Peniston, Joseph B., 35 Jefferson Street, Newnan
St. John, James O., Newnan
Smith, William Posey, Jr., Bowdon
Tanner, W. H. (Life), Route 2, Newnan
Tribble, J. M., Senoia

CRISP COUNTY

Busbee, Perry G., Cordele
Dorminy, J. N. (deceased) (Life), Cordele
Goss, Christopher C., Ashburn
Goss, Woodrow, Ashburn
Gower, Orien T., Jr., Cordele
McArthur, Charles E., Cordele
Welchel, A. J. (Life), Cordele
Williams, H. J., Cordele
Williams, L. E., Cordele
Williams, P. L., Cordele
Williams, P. L., Jr., Cordele
Wooten, L. E., Cordele

DECATUR-SEMINOLE COUNTIES

Baxley, Harry B., Donalsonville
Bellville, Charles George, Bainbridge
Bridges, E. Cleveland, Donalsonville
Bridges, Henry A., Bainbridge
Chason, Gordon, Bainbridge
DuPree, Thomas Earl, Bainbridge
Ehrlich, M. A., Bainbridge
Fort, M. A. (deceased), Bainbridge

Gibson, Frank Leslie, Bainbridge
Griffin, Edwin M., Riverside Clinic, Bainbridge
Jenkins, H. B., Donalsonville
Mosley, E. E., Donalsonville
Tucker, John P., Bainbridge
Wager, William Francis, Park Street, Jacksonville, Florida
Welch, Carl B., Attapulgus
Wheat, R. F., Bainbridge
Willis, L. W., Bainbridge
Wright, Jones Thomas, Donalsonville

DEKALB COUNTY

Allen, Homer H., 520 Church Street, Decatur
Ansley, Robert B., 121 Clairmont Avenue, Decatur
Beck, John E., 356 W. Ponce de Leon Avenue, Decatur
Bloomer, Wm. Earl, 520 Church Street, Decatur
Buchanan, L. C. (Assoc.), 215 Church Street, Decatur
Carter, Henry Grady, Jr., 459 Candler Road, S.E., Decatur
Cooley, Joseph Bernard, 1051 Second Avenue, Decatur
Cunningham, C. E., 106 East Ponce de Leon Avenue, Decatur
Duncan, G. A., Masonic Temple, Decatur
Evans, J. Rufus, Stone Mountain
Fort, Chester A., Jr., Medical Arts Building, Atlanta
Holbrook, Howell P., Tucker
Joel, Charles, Jr., 2117 N. Decatur Road, N.E., Atlanta
Kerr, William K., Chamblee
Lee, Howard B. (Assoc.), Masonic Bldg., Decatur
Leslie, John T., 518 Marshall Street, Decatur
Litton, James H., Tucker
Matthews, Lawrence P., 1282 S. Oxford Road, N.E., Atlanta
McCurdy, Willis T., Stone Mountain
McGeachy, Thomas E., 520 Church Street, Decatur
Mendenhall, W. A., Chamblee
Morse, Chester W., 348 West Ponce de Leon Avenue, Decatur
Nardone, August Joseph, 68 Avondale Road, Avondale Estates
Pattillo, Charles Edward (Assoc.), 544 E. Ponce de Leon Avenue, Decatur
Petrie, Eleanor Byers, 304 Wilton Drive, Decatur
Pirkle, Quentin Roosevelt, 1593 Candler Road, Brookhaven
Powell, Fincher Carlton* (Assoc.), USN Hospital, Camp LeJeune, N. C.
Sanders, Floyd Roscoe, Jr. (Assoc.) Masonic Temple Bldg., Decatur
Schreeder, John M., Chamblee
Shinall, Robert Phillip, Jr., 231 East Ponce de Leon Avenue, Decatur
Simmons, Malcolm Freeman, 380 West Ponce de Leon Avenue, Decatur
Smith, William Patrick, 319 Church Street, Decatur
Smoot, Richard H., 215 Church Street, Decatur
Stewart, Thomas W., Lithonia
Sweet, Mary F. (Life), 165 South Candler Street, Decatur
Taylor, John Edwin, Jr., 356 West Ponce de Leon Avenue, Decatur
Vinson, T. O., DeKalb County Board of Health, Decatur

DOOLY COUNTY

Coleman, Otha Kinney, Vienna
Daves, V. C., Vienna
Davis, E. B., Byromville
Kitchens, O. W., Byromville
Malloy, Martin L., Vienna

DOUGHERTY COUNTY

Adams, George Bunch, Saluda, North Carolina
Armstrong, Edward S., 410 C & S Bank Building, Albany
Berg, Joseph L., 305 North Jefferson Street, Albany
Bowman, M. B., 403 Broad Avenue, Albany
Brannen, Joseph Harrison, 901 N. Davis Street, Albany
Cook, W. S., 238½ Pine Avenue, Albany
Dunn, Robert George, Jr., 1150 Julia Street, Albany
Field, W. M., Medical Building, Albany
Hill, John Parker, 901 N. Davis Street, Albany
Hilsman, P. L., 200½ Broad Avenue, Albany
Hirschfield, S. A., Albany
Holman, Charles M., 220½ Broad Avenue, Albany
Ingram, Lillian, 210 Callaway Building, Albany
Inman, J. S., Albany
Irvin, I. W. (deceased), Albany
James, Alfred Elmore, 403 Broad Avenue, Albany
Keaton, J. C., C & S Bank Building, Albany
Lamb, Charles Carroll, Phoebe Putney Memorial Hospital, Albany
Lucas, I. M., 222½ Broad Avenue, Albany
McCall, Charles Sinclair, Jr., Liberty Theater Building, Albany
McDaniel, J. Z., C & S Bank Building, Albany
McKemie, H. M., 301 C & S Bank Building, Albany
McKemie, W. Frank, Medical Building, Albany
Neill, F. K., 100 N. Washington Street, Albany
Parrish, Lewis H., 604 N. Monroe Street, Albany
Paschal, Jarvis Dean, 717 N. Monroe Street, Albany
Redfearn, J. A., 222½ Broad Avenue, Albany
Rhyne, W. P., Callaway Building, Albany
Russell, Paul T., 220½ Broad Avenue, Albany
Seymour, Glenn E., 402 Broad Avenue, Albany
Sutton, James Mack, Jr., 412 Third Avenue, Albany
Thompson, Frederick Haller, Phoebe Putney Memorial Hospital, Albany
Thomas, Frank E., C & S Bank Building, Albany
Thomas, N. R., C & S Bank Building, Albany
Tye, J. P., 220 Broad Avenue, Albany
Wolfe, David M., 400 Highland Avenue, Albany
Wood, Franklin Fay, Jr., Phoebe Putney Memorial Hospital, Albany

ELBERT COUNTY

Arnold, M. H. (Assoc.), Elberton
Bailey, D. V., (Life), Elberton
Johnson, A. S. (Life), Elberton
Johnson, A. S., Jr., Elberton
Johnson, J. E. (Life), Elberton
Johnson, J. E., Jr., Elberton
Jones, Rembert C. (Scientific), 215
Elbert Street, Elberton
Mattox, B. B. (Life), Elberton
Mickel, Carey A., Jr., 10 West Church
Street, Elberton
O'Neal, John B., III, Elberton
O'Neal, Phyllis Johnson, Elberton
Singleton, Charles K., Elberton
Smith, A. C. (Life), Elberton
Smith, F. A., Elberton
Thompson, D. N. (Life), Elberton
Ward, G. A. (Life), Route 1, Elberton

EMANUEL COUNTY

Brown, R. G., Swainsboro
Powell, C. E., Swainsboro
Smith, D. D. (deceased), Swainsboro
Smith, H. W., Swainsboro
Youmans, S. S., Swainsboro

FLOYD COUNTY

Andrews, Russell Edgar, Jr., 2 Berck-
man Lane, Rome
Banister, W. G. (Life), RFD 2, Rome
Battle, Lee H., Jr., Rome
Black, Robert Jacob, Rome
Blalock, Frank A., Battey State Hos-
pital, Rome
Bosworth, Edward L., Rome
Brannon, Emmett, Rome
Brooks, William Henry, Lindale
Chandler, J. L. (Assoc.), Rome
Corpe, Raymond F., Battey State Hos-
pital, Rome
Coslett, Floyd (Assoc.), Box 1411,
Lantana, Florida
Crenshaw, Fred, Battey State Hospital,
Rome
Crow, H. E., Battey State Hospital,
Rome
Culbreth, Ernest Wayne, Lindale
Davis, Ralph J., Rome
Dawson, Harry, Shannon
Dellinger, Raiden W., Rome
Gafford, August Vincent, Harbin Clinic,
Rome
Garner, J. S., Jr., Rome
Garrard, J. L. (Life), Rome
Harbin, B. Lester, Rome
Harbin, R. M., Jr., Rome
Harbin, Thomas S., Rome
Harbin, William P., Jr., Harbin Clinic,
Rome
Horton, Hobart Cleveland, Jr., 5 Chero-
kee Street, Rome
Jenkins, O. W., Lindale
Johnson, Ralph N., Rome
Ketchum, Walter Harris, Battey Hos-
pital, Rome
McCall, John T., Jr., Rome
McCord, M. M. (Life), (Deceased),
Rome
McCord, Ralph B., Rome
Methvin, S. R. (Assoc.), Lindale
Moore, Charles Watson Cary, 409
South Broad Street, Rome
Moore, Clifford, Lindale
Moore, Clifford, Jr., 409 South Broad
Street, Rome
Moss, T. H., Rome
Mull, J. H., Rome
Norton, Robert F., McCall Hospital,
Rome

Orton, Sarah Patterson, Battey Hos-
pital, Rome
Perkins, George Edwin, II, Battey Hos-
pital, Rome
Routledge, A. F., Rome
Sewell, W. A. (Life), 106 Charlton
Road, Rome
Smith, George B., Rome
Smith, Inman, Rome
Smith, Stephen David, Rome
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1. Hild, A. M.: Schweiz. med. Wchnschr.
71:557, 1941.

2. New and Nonofficial Remedies,
J. B. Lippincott Co., Philadelphia, 1953, p. 200.

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1. Dill, J. L.: *Postgrad. Med.* 4:413, 1948.

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2. Schroeder, H. A.: *Circulation* 5: 28, 1952.

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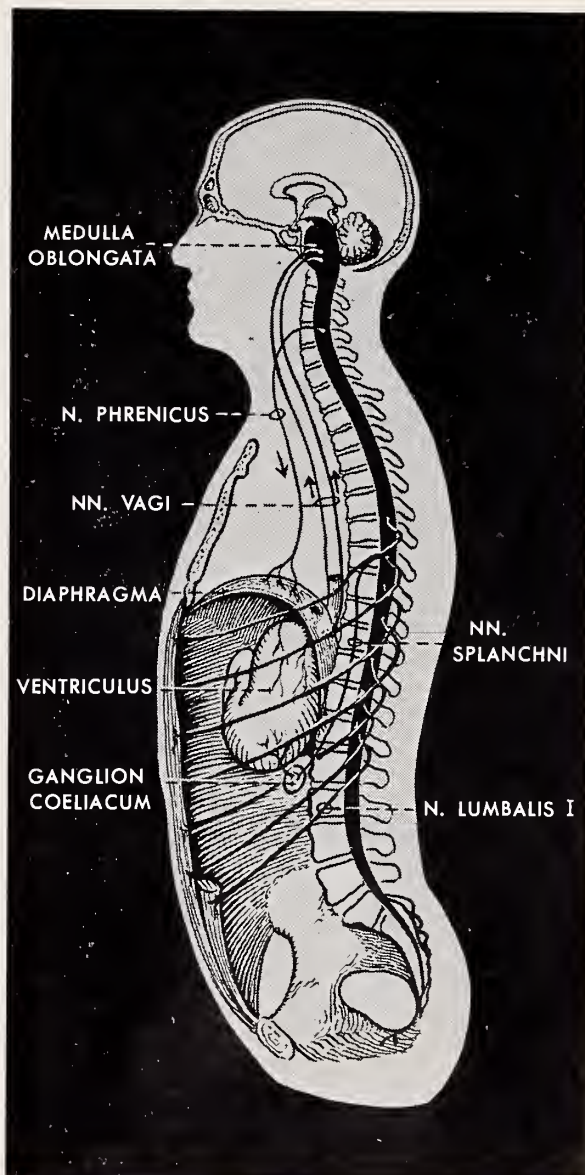
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1. Keats, S.: Ataxic Cerebral Palsy with Akinetic Seizures: Dramatic Response to Dramamine, *J. M. Soc. New Jersey* 50:53 (Feb.) 1953.

2. Council on Pharmacy and Chemistry: *New and Nonofficial Remedies*, 1953. Philadelphia, J. B. Lippincott Company, 1953, p. 471.



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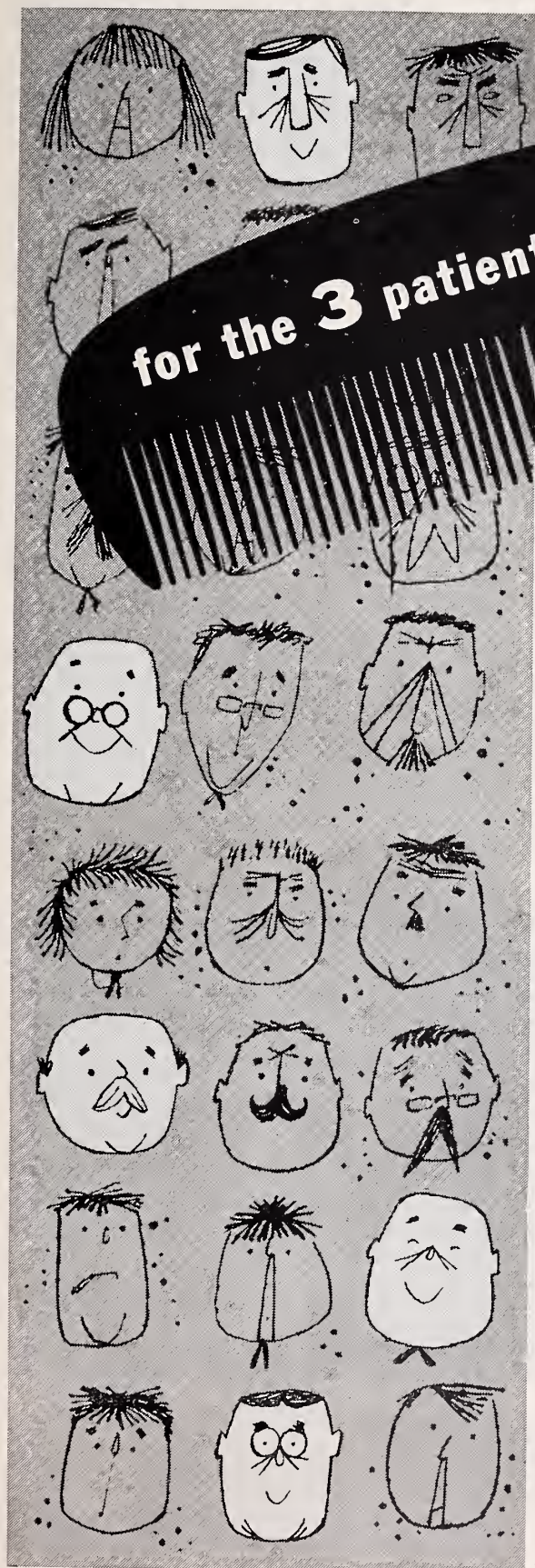
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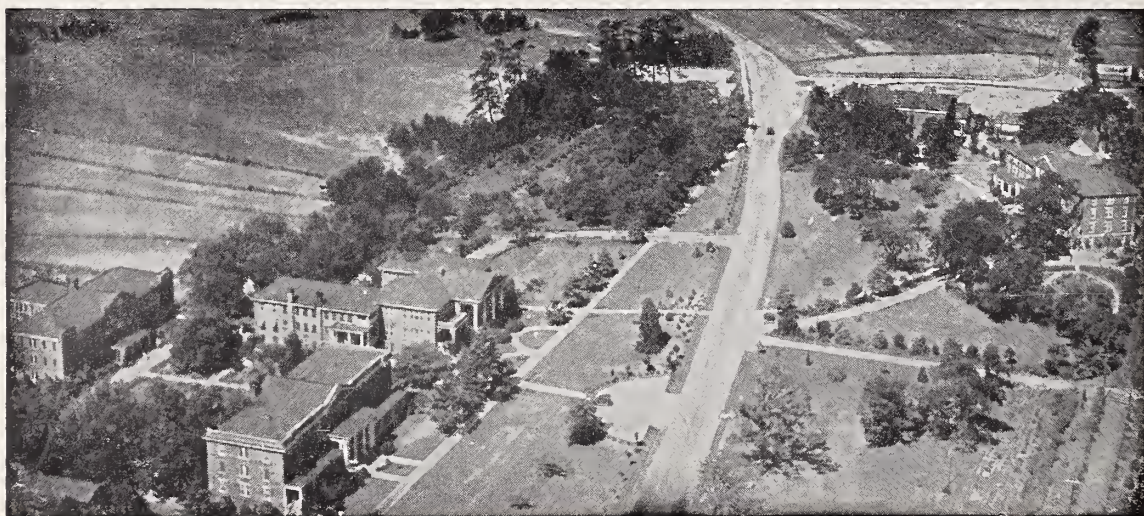
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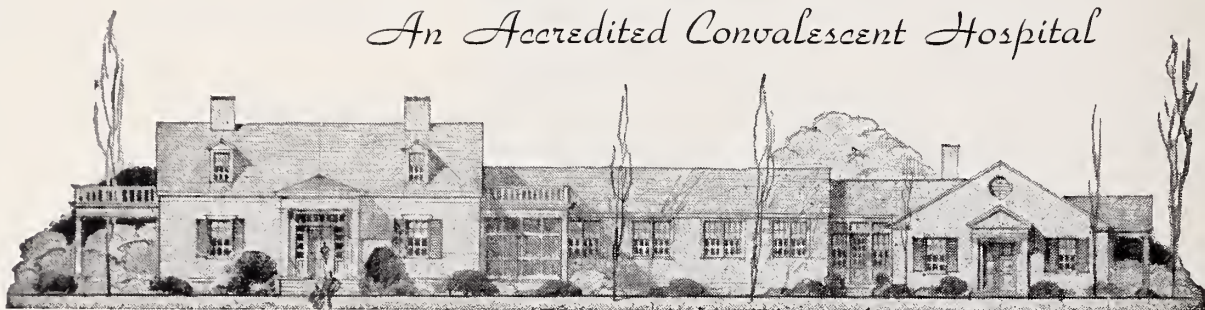
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From where I sit
by Joe Marsh

A Case of "Moostaken" Identity

Slim Smith never had a chance to use his moose call until a trip north this year. Visited him yesterday to see what he'd bagged.

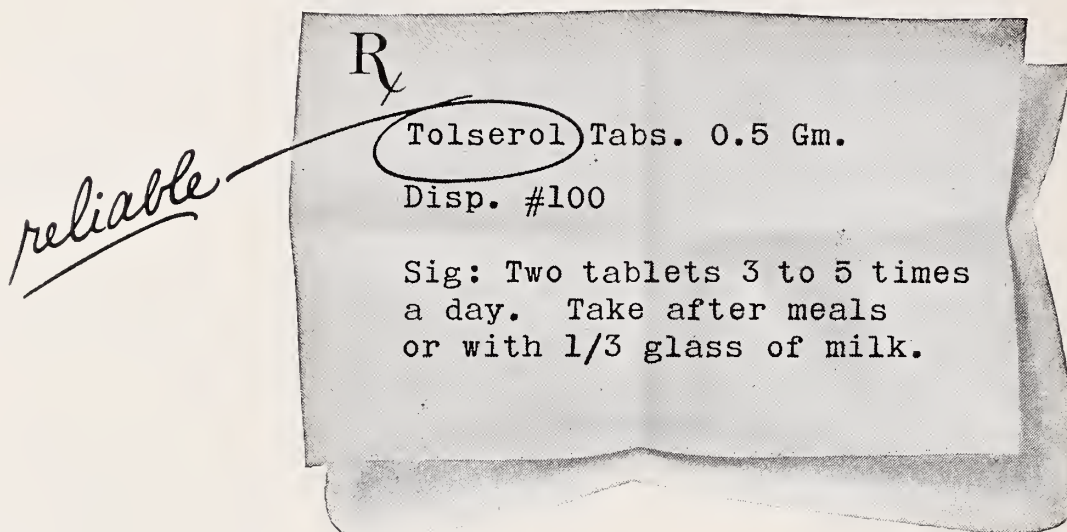
"First day out," he told me, "I picked up a trail. I sounded the call and waited. Then I heard a moose call. Sure enough, something came crashing through the brush. But it was another guy with his moose call. Boy, did I get my finger off the trigger in a hurry!"

My last day there I picked up another trail. And this time I got me a real moose. But you can bet your bottom dollar I took a good look before I did any shooting!"

From where I sit, we could all learn a little from Slim's experience. Most of us are guilty sometime or other of being too quick on the trigger. Like the fellow who would tell me how to practice my profession . . . or even deny me an occasional glass of beer with my dinner. I say that kind of "aim" is way off!

Joe Marsh

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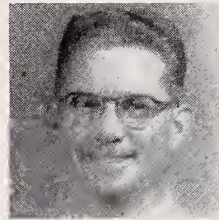
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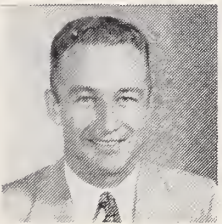
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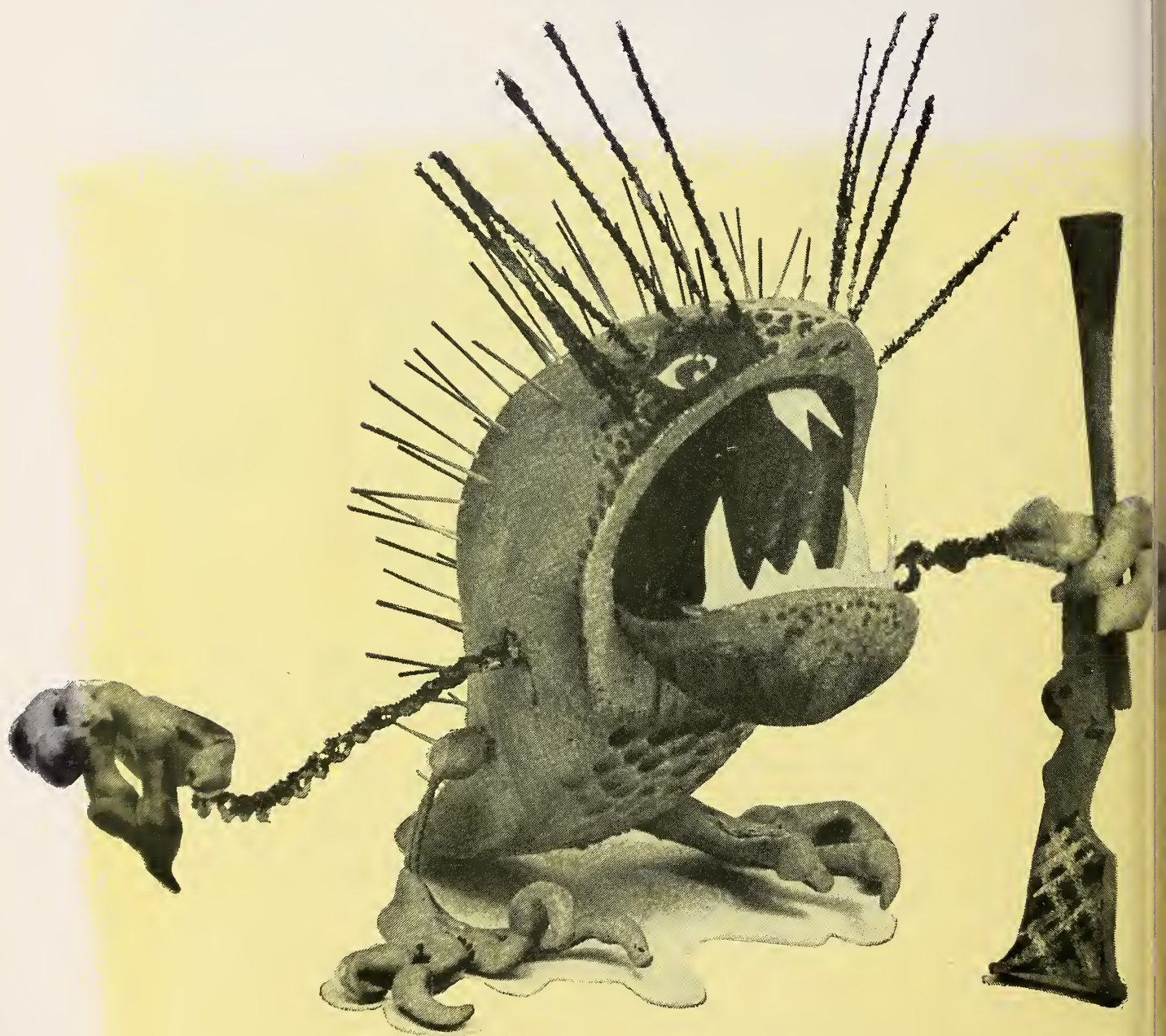
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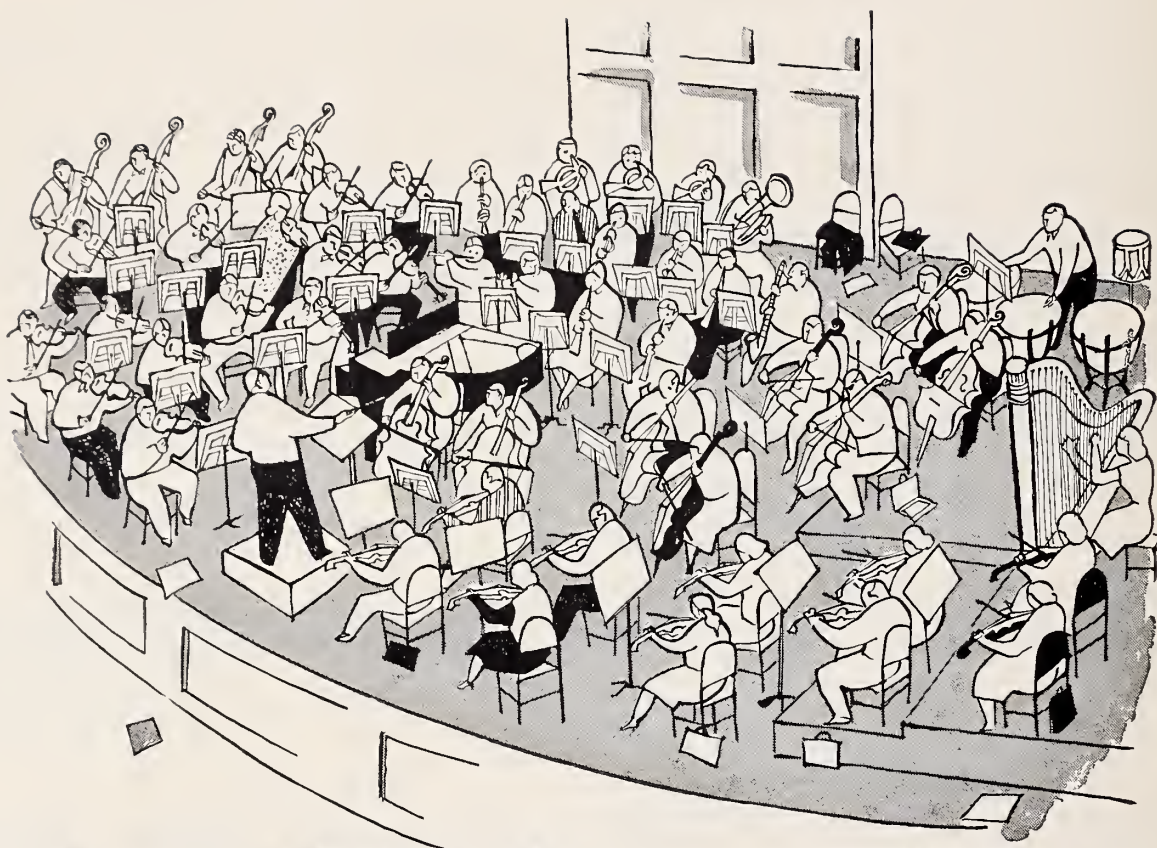
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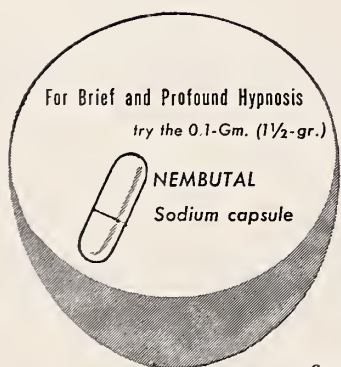
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COVER. The photograph showing a doctor's hands percussing a patient's chest was taken by Ted F. Leigh, M.D., photographic editor of the JOURNAL. The picture points up the first in a series of Heart Pages which will be found each month in the back of the scientific section. The first article is called, "Rest in Heart Failure."

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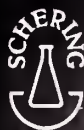
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hospital page



Turner County Hospital Ashburn, Georgia

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reception of patients on September 28, 1953. The capacity of this hospital is twenty-five beds. This is the first hospital to be operated in this community.



Peach County Hospital Fort Valley, Georgia

The Peach County Hospital, Fort Valley, Georgia, was opened October 26, 1953 for the reception of

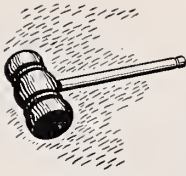
patients. This hospital has twenty-five beds. This is the first hospital in the community. Prior to the opening of the hospital, several small clinics were operated by individual physicians.

VA Tuberculosis Survey

For the past four years, the Veterans Administration has conducted the most extensive war on tuberculosis among veterans ever known in the history of the country.

In announcing the results of the program today, VA said they are so significant that they are expected to pay health dividends to the entire nation.

In the four year period that the program has been under way on a fully implemented basis, VA has screened 3,217,000 persons for TB. These include 2,513,000 patients and 704,000 employees. Among these two big groups, VA discovered 12,740 cases of active pulmonary TB and 34,470 cases of inactive pulmonary TB.



president's page

As the year goes along and much time is spent with the affairs of our Association, there is an opportunity to assess the various factors which determine the place organized medicine will have in our changing socio-economic civilization. To the best of their ability the majority of doctors continue to give prompt, efficient, courteous service to their patients, making a reasonable charge to those who are able to pay and taking care of the indigent without compensation.

The cause of many of our problems has been beyond our control. Certainly we were not responsible for the depression in the early 30's when the government first sponsored the social welfare program that has continued to the present day. The present administration has emphasized the need for the federal government to provide security for all the people and very little has been said about the importance of an individual providing for his own welfare.

The impact of World War II and the Korean conflict on our civilian medical manpower combined with the effect of a long period of uninterrupted economic prosperity have conditioned certain members of our profession to an indifferent attitude towards the medical needs of the public. While insisting that our house be cleaned, we must be reminded that one major difficulty is that doctors are ordinary human beings when it comes to taking advantage of an opportunity to make money. At the same time, we must express our disapproval of several articles that have appeared in the lay press recently, in which our short comings have been magnified and, by omission, our admirable accomplishments have been minimized.

It is a well known fact that the volume demand for medical attention varies directly with the economic welfare of our nation. If the time should come when this demand decreased to the point where occasionally a doctor would wait anxiously for the next patient to walk into his office, the majority of our public relations problems would disappear. Lacking this, our corrective efforts should be doubled. However, one should expect no miracles and the final result will determine the number of friends we make and influence. These latter comments are by no means evidence of pessimism but rather emphasis on realism in an effort to have a better understanding of those things which play an important part in shaping our medical destiny.

WILLIAM HARBIN

editor's mail



To the Editor:

I have just finished reading the December issue of the Journal. It is certainly the best yet. I was pleased to see that the suggestions brought forward at the recent meeting have already been put into effect. The more conservative titles, the elimination of advertising material in the scientific section, and the beginning of each scientific paper at the top of a page, all add to the dignity and visual appeal of your excellent magazine.

Sincerely yours,

R. H. STEPHENSON, M.D.
Atlanta, Ga.

To the Editor:

You as the Editor of the Journal of the Medical Association of Georgia will be interested to learn that yesterday the 100,000th reprint of the essay "Can You Retire, Doctor?" written by our member Dr. Robert Scharf, Associate Professor of Georgia Tech and published in your March 1953 edition as the first article in a series of medical economics, has been sold. This article has been requested for distribution not only all over the United States, but also in Canada and inquiries came even from Central America. Thus not only the name of Georgia Tech but also of your fine Journal has been brought into all corners of our country.

The third article by Dr. Scharf, "The Great Fallacy," published in your November 1953 issue, has been requested so far in 22,000 reprints—and this within a few weeks. It probably would interest your own members to know this.

Professor Scharf also received an invitation from Dr. R. H. Randolph, Athens, Ga. to be the guest speaker at the next meeting of the Clarke County Medical Society on January 26 at 7:30 p.m.

With best wishes for 1954 and kindest regards to you and to the members of your editorial staff,

Very truly yours,

M. SLOAN, LL.B.
Consulting Economists
Assoc. of Research
Specialists

To the Editor:

I want to thank you and also compliment you upon the unique Christmas card which your asso-

ciation sent me. It is excellent. With best wishes for 1954, I remain

Sincerely,

R. H. KAMPMEIER, M.D.
Editor and Secretary Tennes-
see State Medical Assoc.

To the Editor:

At this Christmas season I would like to express again my sincere appreciation for our Associations very friendly gesture of making me a Life Member. I think it is a wonderful thing to do, and my Golden Card of membership is something that I treasure very highly.

I would like to say, thanks, also, for the gift copies of our fine Journal. Such publications don't just happen. They are the product of a lot of work and deep thought. To each and every one of you who put such effort into it I want to say, please accept my thanks.

With best wishes to all for a Merry Christmas and a Happy New Year, I am

Very sincerely,

EMORY R. PARK, M.D.
LaGrange, Ga.

To the Editor:

It would be greatly appreciated if you would include this notice in the next issue of the Georgia Medical Association Journal.

The Southeastern Allergy Association will hold its annual meeting at the Dinkler-Plaza Hotel, Atlanta, Ga., March 25-27, 1954. Dr. Katharine Baylis MacInnis, 1515 Bull St., Columbia, S. C., secretary.

Thanking you for this consideration, I am,

Very truly yours,

KATHARINE BAYLISS MacINNIS, M.D.
Columbia, S. C.

To the Editor:

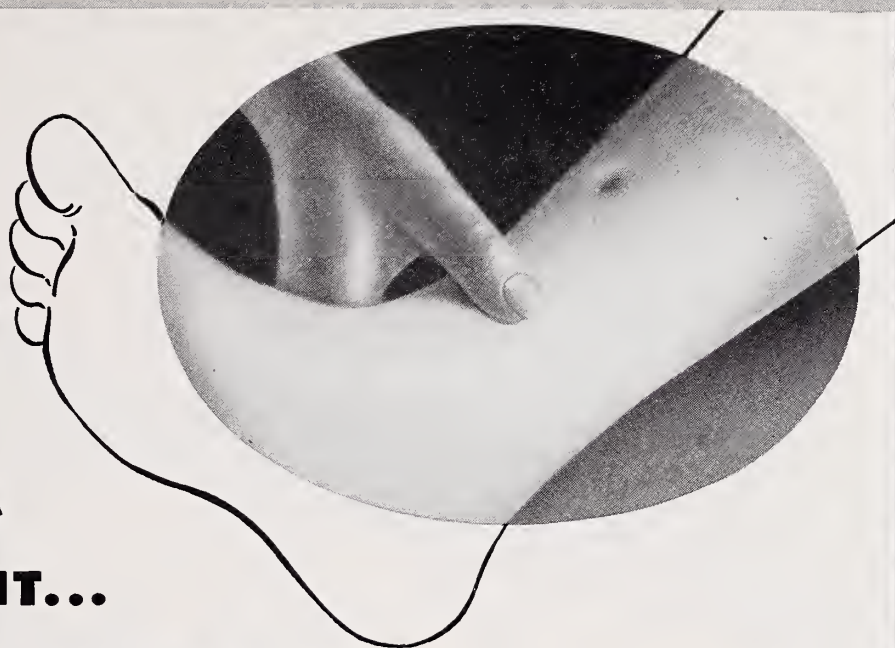
Congratulations on your Christmas number and best wishes to you and yours for the holidays.

Fraternally yours,

HAL M. DAVISON, M.D.
Atlanta, Ga.

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1. Abramson, Julius, Bresnick, Elliott, and Sapienza, P. L.: *New England Jour. Med.*, 243:44, July 13, 1950.

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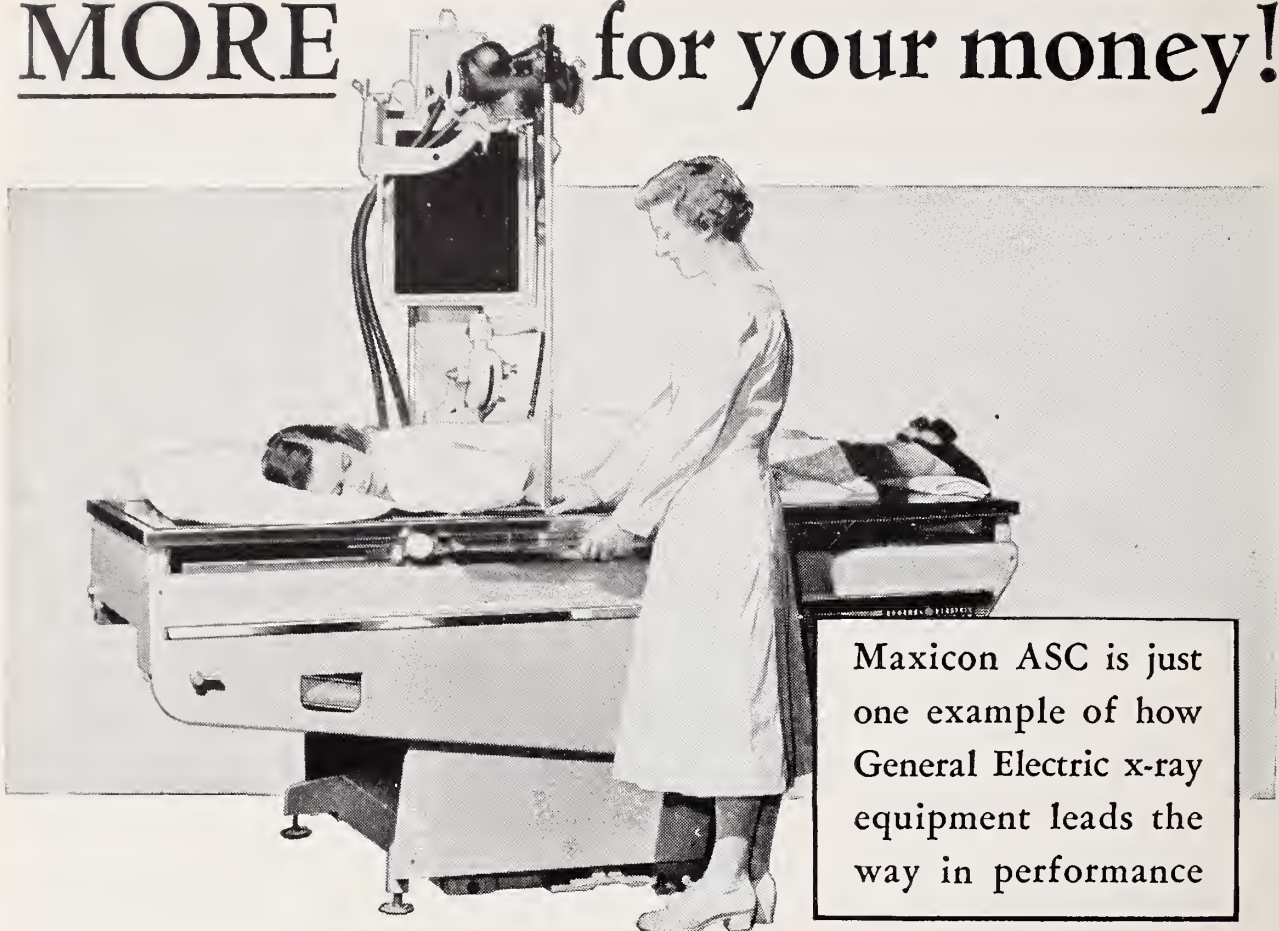
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physician's bookshelf

BOOKS RECEIVED

REVIEW OF PHYSIOLOGICAL CHEMISTRY, Harper, Harold A., Los Altos, California, Lange Medical Publications, University Medical Publishers, 1953, 328 pages, \$4.00.

INTERRELATIONS BETWEEN THE SOCIAL ENVIRONMENT AND PSYCHIATRIC DISORDERS, Milbank Memorial Fund, New York, 1953, 265 pages, \$1.50.

PSYCHOTIC AND NEUROTIC ILLNESSES IN TWINS, Eliot Slater, Privy Council, Medical Research Council Special Report Series, No. 278, London, Her Majesty's Stationery Office, 1953, 385 pages, \$4.75.

THE HISTORY OF THE MEDICAL DEPARTMENT OF THE UNITED STATES NAVY IN WORLD WAR II, Navmed P—5021, Vol. 2, United States Printing Office, Washington, D. C., 1953, 235 pages.

SCIENCE AND MAN'S BEHAVIOR, Dr. Trigant Burrow, New York, Philosophical Library, 1953, 564 pages, \$6.00.

SCHOOL HEALTH SERVICES, Dr. Charles C. Wilson, New York, National Education Association and American Medical Association, 1953, 486 pages, \$5.00.

REVIEWS

TEXTBOOK OF SURGERY Edited by H. F. Moseley, M.A., D.M., M.Ch. (Oxon), F.A.C.S., (Eng.), F.R.C.S. (C). Foreword by G. Gavin Miller, M.D., C.M., M.Sc., F.R.C.S. (C), F.A.C.S.

This is an excellent textbook of surgery which was written primarily for the medical student by members of the Surgical Department of the Royal Victoria Hospital and of the Departments of Neurosurgery, Obstetrics and Gynecology, and Pathology, all associated with McGill University.

All surgical sub-specialties are included except Eye, Ear, Nose and Throat and Gynecology.

This text is based on sound surgical principles, clearly and concisely written. Anatomy, physiology and pathology are integrated within the book and not dealt with as individual components. The book is profusely illustrated with excellent photographs, drawings and color plates. It is not a book for the surgical resident or practicing surgeon. It was not written for that purpose.

Medical students should receive this book with great enthusiasm. Mastery of this *Textbook of Surgery* would give one an excellent foundation for further advancement in surgery.

SURGICAL PATHOLOGY by Lauren V. Ackerman, M.D. Professor of Surgical Pathology and Pathology, Washington University, School of Medicine; Surgical Pathologist, Barnes Hospital and affiliated Hospitals, St. Louis; Consultant to the Ellis Fischel State Cancer Hospital, Columbia, Missouri; Consultant to the Armed Forces Institute of Pathology. Pp. 836. Illustrations 913. The C. V. Mosby Company. St. Louis, 1953.

The student of surgical pathology will find in this book a welcome addition to his library. This is, above all, a readable book. A durable binding and the use of glossy-surface paper gives a pleasing appearance. The type is large; illustrations and photographs are excellent. These are clear, distinct and numerous. The titles and subtitles stand out nicely.

The general organization of the subject matter is well done. Chapter headings are according to organs and organ systems. Each chapter is preceded by a succinct outline of the material contained therein. An introductory paragraph expressing the "why" or "cause-for-existence" of the chapter follows this section. Perhaps the most valuable part of the book is the comprehensive and up-to-date bibliography at the end of each chapter, arranged according to chapter outline.

This book cannot be expected to furnish in detail all of the information available in the vast field of surgical pathology. It makes no attempt to do so. If it did, it would lose its value as a textbook for the medical student or general surgeon. On the other hand, the subject matter is comprehensive, and many rare and interesting diseases are mentioned briefly.

When the content of this book is examined critically a number of inconsistent and dogmatic statements and errors, both of omission and commission, are noted. In the introductory chapter the statement is made that the surgical pathologist "must have a rich background of clinical medicine" but a portion of Chapter Two, which deals with non-neoplastic skin conditions, is written by a non-medical colleague. This is difficult to understand. In Chapter Nine under the discussion of esophageal diverticula,

epiphrenic diverticula are classified as traction diverticula, when they are generally felt to be of the pulsive type. The dogmatic and erroneous statement is also made that carcinoma does not arise within such diverticula.

The entire discussion of the clinical findings in acute cholecystitis is limited to this single sentence: "In acute cholecystitis the clinical symptoms and signs are those of an acute abdomen." Incomplete is a gross understatement. Chronic relapsing pancreatitis is certainly as important as some of the rare conditions described and there is available considerable literature on the subject, but the author does not mention it.

In spite of these and other errors, which, it is hoped, future editions will see corrected, this book fulfills a vital need and can be highly recommended.

THE ANATOMY AND SURGERY OF HERNIA by Leo M. Zimmerman, M.D. and Barry J. Anson, M.D. Published by The Williams & Wilkins Company. 366 pages.

This excellent monograph by Zimmerman and Anson fills a great need to simplify and correlate the knowledge of hernia. The present treatment is based on the fundamental concept of the anatomy and the exact principles of restoration of the defects that exist. This is adequately furnished by this concise but detailed study.

The anatomy is presented to clarify some of the controversial features that exist. The use of the text for students, both undergraduates and graduates, is particularly good, since there are few details omitted.

The drawings are of the very highest type and are extremely clear in detail. This should prove beneficial for the experienced surgeon as a reference to this most frequently encountered condition.

Mrs. Bruce Shaefer Elected

Mrs. Bruce Schaefer of Toccoa, Ga. was recently elected Acting Chairman of The Better Health Council of Georgia at the January Board Meeting of the Council. Mrs. Schaefer, who is interested in the Health of Georgia in the local communities and the state as a whole, is eminently qualified for leadership

in this state group of official and voluntary health agencies.

Due to serious illness in her immediate family, Mrs. H. Stewart Wootten requested that she retire as Chairman of the Council.

THE ATLANTA GRADUATE MEDICAL ASSEMBLY

will hold its annual meeting

February 22, 23, and 24, 1954 ● Biltmore Hotel ● Atlanta, Georgia

- | | |
|---|---|
| <ul style="list-style-type: none"> ● Symposium on Isotopes ● Symposium on Gastro-enterology | <ul style="list-style-type: none"> ● Symposium on Cardiology ● Symposium on O.B.-GYN. |
|---|---|

AMONG THE DISTINGUISHED GUEST SPEAKERS

DR. CHARLES A. DOAN
Dean, College of Medicine
Ohio State University
Columbus, Ohio

DR. R. L. SANDERS
Director, Sanders Clinic
Memphis, Tenn.

DR. DONALD D. MATSON
Neuro-Surgeon
Children's Hospital
Boston, Mass.

DR. EDGAR R. PUND
President
Medical College of Georgia
Augusta, Georgia

DR. VIRGIL S. COUNSELLER
Head of Section in General and
Gynecological Surgery, Mayo Clinic
Rochester, Minn.

DR. ELMER BELT
Director
Elmer Belt Urologic Group
Los Angeles, Calif.

DR. DOROTHY H. ANDERSEN
Pediatrician
Presbyterian Hospital
New York, N. Y.

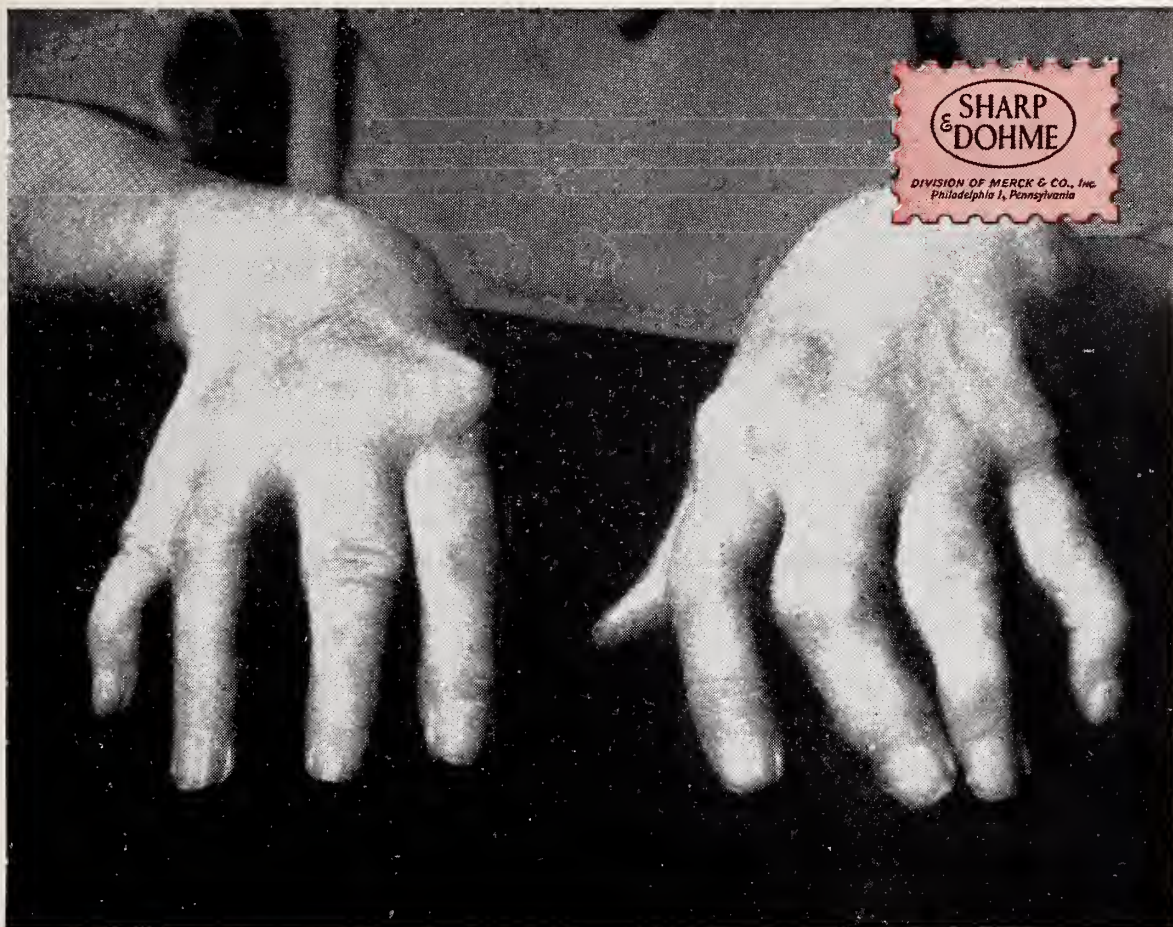
DR. J. W. McCALL
Chief Dept. of Bronchoscopy and
Esophagoscopy, Huron Hospital
Cleveland, Ohio

DR. HERMAN K. HELLERSTEIN
University Hospitals
Cleveland, Ohio

DR. CARL MUSCHENHEIM
Assoc. Professor of Clinical Medicine
Cornell Medical School
New York, N. Y.

DR. R. GORDON DOUGLAS
Obstetrician and Gynecologist In Chief
New York Hospital
New York, N. Y.

DR. ALLAN C. BARNES
Professor of Obstetrics and Gynecology
Western Reserve University School
of Medicine
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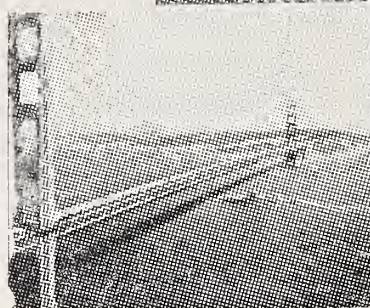


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THE DEAN, 345 West 50th Street, New York 19, N. Y.

the executive secretary's letter

1954 MAG Program

At the recent MAG Council Meeting, January 17, Council approved a platform for the Association for 1954. These items are the goals of the Association's activity this year. Specifically the objectives are as follows:

1. Adequate Physician Care for the Citizens of Georgia.
2. Voluntary Insurance Plan to be supported by MAG Physicians.
3. Increased MAG Physician Support of the American Medical Education Foundation.
4. MAG Assistance to Communities in Securing Physicians Where Need Exists.
5. MAG Physician Support of Better Health Programs for All, and Especially for Children, and Elderly Persons.

Other points of the program for consideration and action are Emergency Call Systems, M.D. Speakers for Lay Groups, Minimum Standard of Blood Banks, Disaster Defense, etc.

This program will be brought before your county society in brief 6 minute talks given by personnel of the MAG Headquarters Office within the next two or three months. This "grass roots" approach will become the main function of the Headquarters Office.

Memorial Issue

The next issue of the *JMAG* will be dedicated to the memory of Dr. Crawford W. Long and his discovery of ether as an anesthetic—Jefferson, Georgia, March 30, 1842. Outstanding physicians in the field of anesthesia will contribute scientific articles. Look for this memorial issue next month.

New MAG Committees

Two new committees have been recently formed to further Association activity. The committees are: *Committee on Mental Health*, J. R. Shannon Mays, Macon, chairman; Paul L. Schroeder, Atlanta; Paul Scoggins, Commerce; Guy Rice, Atlanta; R. D. Walters, Calhoun and Gibson K. Cornwell, Fitzgerald—*Crawford W. Long Memorial Committee*, Lester Rumble, Jr., Atlanta, chairman; Perry P. Volpito, Augusta and A. B. Boyd, Athens.

Congress, U.S.A.

As individual physicians you are urged to watch the Washington Scene and formulate your opinion in matters pertaining to proposed legislation in the medical field. It is likely that a "National Health Act of 1954" will be proposed by the administration.

By the time you read this you will know the answer. Your Association stands ready to act on the basis of your opinions.

Society Constitutions

Recently a County Medical Society wishing to take appropriate action along certain lines found to their consternation that the County Society Constitution and By-Laws was non-existent. Having been written some 40 years ago, it was lost in the shuffle.

Every County Medical Society must have a **Constitution and By-Laws** which should be kept up to date and amended as necessary. While it was feasible to give curbstone opinions on *Robert's Rules of Order*, it is now necessary to operate from listed procedures. The Headquarters Office will gladly provide "model" County Medical Society Constitutions for guidance.

Mediation Committees

Formerly called "Grievance Committees," County Society Mediation Committees are considered a *must* for effective public service. If your Society has such a committee, you already know the value of it. If your Society does not have one—start the new year with its organization. It will benefit every member of your organization—and remember that forming it is not enough. It must be publicized so the public will know of its existence. Again, the Headquarters Office will aid you in starting this service to the public.

Locations and Physicians

Your attention is called to the "Doctor Placement" page in this issue of the *JMAG*. This page gives a list of locations in the state of Georgia seeking physicians and also gives a list of physicians seeking Georgia locations. It is not feasible to carry on this page *all* the details now listed in the Headquarters Office Placement file. The data concerning a physician's medical background, specialty, etc. and information about community facilities, churches, schools, etc. will be gladly furnished on request by the Headquarters Office.

County Society Problems

Your County Medical Society's success is the main concern of the MAG. The State Association seeks to serve your society and it is the duty of the Headquarters Office to expedite this program of service.

Milton D. Krueger
Executive Secretary

the month in washington

Eisenhower's Program

Washington, D. C.—Although the budget, defense and farm policy are monopolizing Washington headlines, Congress is paying more than casual attention to the health and social security fields. In these, as in other legislative areas, it has for its guidance a specific program, laid down by President Eisenhower in his various messages during the first few weeks of the session. The question now is whether this closely-divided Congress will have the time and/or the inclination to follow through on everything the Administration wants.

Before Congress settled down to its task, the President met with a group of American Medical Association leaders, who discussed with him the Association's position on several important pieces of legislation. Present at the White House meeting, in addition to Mr. Eisenhower and Sherman Adams, Assistant to the President, were AMA President Edward J. McCormick, Trustees' Chairman Dwight H. Murray, President-Elect Walter B. Martin, and Washington Office Director Frank E. Wilson.

Voluntary Health Insurance

Congress got into the health and welfare field with no waste of time. Within five days after Congress reconvened the House Interstate and Foreign Commerce Committee, under the chairmanship of Rep. Charles Wolverton (R., N. J.), began an exhaustive series of hearings on voluntary health insurance, further evidence that the Administration is determined to get some action in this direction.

Chairman Wolverton as long as four years ago was interested in legislation to help pre-paid insurance programs extend their coverage and increase their benefits. In 1950 he incorporated his ideas in a bill, but it was not acted upon by the committee and was not revived until this year. Now the atmosphere is much more favorable for Mr. Wolverton's proposal. Not only is he chairman of the committee and his party in control of Congress, but his ideas have strong support from the Administration.

Basically the Wolverton idea is an FDIC for voluntary health insurance. In about the same way the Federal Deposit Insurance Corporation insures bank deposits up to a certain limit, the Wolverton program would insure (or re-insure) various types of hospital, surgical, and medical insurance programs. The proposal is for the federal government to set up a national health insurance underwriting corporation. To keep the corporation going, the member plans would contribute a certain percentage of their gross receipts, possibly 2 per cent.

With the national corporation underwriting unusual risks, the individual programs could offer

catastrophic or "complete" coverage. By scaling individual premiums to the family income, the member plans also could offer protection to families with very low incomes. The national corporation would pay possibly two-thirds of each subscriber's claim in excess of, say, \$500 or \$1,000 in any one year.

Income Tax Deductions

Another piece of legislation, receiving favorable attention, also would help families with their medical expenses—a proposed liberalization of income tax deductions allowed for medical expenses. Under present law, only that part of medical expense exceeding 5 per cent of taxable income may be deducted. The pending legislation would drop this to probably 3 per cent, and raise or eliminate the maximum limit.

Vocational Rehabilitation

Secretary Hobby's Department of Health, Education and Welfare is firmly behind a proposal to have the federal government show more leadership in vocational rehabilitation of the handicapped. At this writing it is too early for any good indication as to whether physicians will be brought under social security. The Administration's bill would blanket in most self-employed groups, including dentists, attorneys, architects and farmers, in addition to physicians.

Military Dependents

From all indications available during the first few weeks of Congress, a showdown fight may be unavoidable on medical care for military dependents. Defense Department, with support from the President, wants dependent care extended and made uniform among the three services, with military physicians carrying as much of the responsibility as they can. Under the Defense Department plan, dependents who could not be taken care of at military installations would be allowed to obtain their care from private sources, with the government paying almost all of the cost.

The American Medical Association agrees with the Defense Department that all dependents should receive medical benefits as nearly uniform as possible. However, AMA contends that wherever possible dependents should use private physicians and private hospitals, and that the military personnel and facilities should be employed only where civilian facilities are inadequate.

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VA MEDICAL CARE

IT IS NOW AN accomplished fact that the United States is embarked upon a tremendous hospital and medical care program for veterans, financed and conducted by the Federal Government. This program is now squeezing the enterprise, the individuality, the freedom of choice and freedom of desire out of a large segment of our citizenry. It can in the future bring us to a government not of the people, but in spite of the people—a government not for the people, but for the veteran and a government not by consent, but by dictation.

The abuse of the medical service of the Veterans Administration by some former servicemen, with complicity of the Veterans Administration's officers, by a small membership in the American Legion and, sad to relate, by some medical men and some medical schools, has grown to huge and dangerous proportions.

If these abuses are allowed to continue, by giving free medical care to any veteran for any illness or injury they might incur, we will have in twenty years socialized medicine in the United States without changing our laws—a type of socialized medicine for a privileged few, paid for by the whole.

Who can stop it? You, the physician. You, who gives this service. You who gives this service by compliance, by paid service either direct or under the disguise of a teaching program in medical schools. Or you who turn your back on unpleasant facts.

You, the physician, can break this chain of events before the chain binds you to the serfdom of government medicine.

How can you stop it? By simply refusing to be a party to these abuses, by teaching your patients individual responsibility pertaining to matters of personal health; by taking a courageous stand for sound principles in the care of public health, so as to give wise guidance to your patients and our congress, and, by actively endorsing and explaining those principles outlined by your American Medical Association.

The welfare of the whole nation depends upon your personal efforts in your community—let us work at it.

No matter how well greased in monetary benefits or by public necessity it may be, you cannot allow this "crown of thorns" to be pressed down upon the brow of American medicine.

Herbert Alden, M.D.

DID YOU KNOW?

IN THREE PREVIOUS articles we have attempted to arouse your interest with the fact that the three outstanding causes of maternal mortality in our State are hemorrhage, toxemia and sepsis. Although there has been a decrease over the years in our maternal mortality, mothers still die. It should be our aim for the future to conserve the lives of our mothers. Much can be done through the collective resources of the community. It should be a challenge to the physicians, nurses, public health personnel, educators and community leaders.

The decrease in our mortality rate has already been accomplished by many factors. Mothers today are receiving better obstetrical practice, more extensive and more adequate prenatal care, increased use and improvement of hospital facilities and services, avail-

ability of chemotherapeutic agents, antibiotics, blood and blood derivatives.

It should be our aim to provide widespread distribution through educational materials to the public concerning the importance of good medical care and competent obstetrical care, including adequate prenatal, natal and postnatal attention. We should encourage modern hospital facilities with well-trained personnel to provide for mothers, and make use of these facilities. The people should be made aware of the role of public health nursing services. Physicians should provide safer obstetrics and determine preventability through a study of all maternal deaths.

*MAG Maternal and Infant
Welfare Committee*

AN ANESTHETIC COMMISSION

DEATH ON THE highways of our state is a frequent occurrence. Each death receives a varying amount of publicity. Many rate "headline" attention. Any center of government, from the smallest hamlet to the state capitol, can readily give an interested party accurate statistics regarding these deaths. In most instances, the cause of the accident is recorded. Varying degrees of investigation have been accomplished.

Could you guess, with any degree of accuracy, the number of deaths that have occurred during surgical intervention within the past year in our state? How well have these mortalities been catalogued? Can any one answer the question, "Is cardiac arrest increasing with the use of varied anesthetic agents and with the extension of surgery to ever widening fields of endeavor?" Will the mortality rate from surgery decrease or increase over the next ten years? Do you benefit fully from such an occurrence in your own practice? As doctors, should we not be able to give an accurate answer to the above questions?

Certainly no one wishes to headline these occurrences, although from time to time a "close call" does receive newspaper attention. There is a method for collecting these statistics which has proved successful in other states. Your Section on Anesthesiology feels that the institution of this method as an official function of the Medical Association of Georgia would be of benefit to the overall practice of medicine within the state. The least it would accomplish is the compilation of accurate statistics regarding surgical and anesthetic mortality.

Several years ago, many medical societies began to establish what have been variously termed "Anesthetic Study Commissions," "Post-operative Study Groups," and "Mortality Study Commissions." The purpose of these groups has been to serve as reviewing board and

statistician for each fatality that occurs on the operating table or within forty-eight hours of surgery. Along with this duty of collecting statistics, goes hand in hand the responsibility of disseminating information that might prevent the repetition of an unnecessary fatality.

The cooperation of the State Department of Health has been assured, thus giving the Commission an accurate count of the number of "surgical and anesthetic" deaths. But with only death certificate information no appraisal can be made with a view toward classifying any particular death as preventable or non-preventable. For this reason a rather simple questionnaire has been worked out, to provide the Commission with enough facts to properly catalogue the occurrence. With sufficient cooperation on the part of the hospitals and physicians of our state, the answers to all of the questions posed will become readily available to those entitled to know the progress (or lack of it) of anesthesia and surgery in Georgia.

Before anyone takes issue with this idea on the basis that it might lead to unwanted publicity, let us assure you that all information is gathered in such a manner as to preclude the identification of the patient, the physician, the hospital, or the locality in which the event takes place. The Commission's findings will be published periodically in the JOURNAL or if necessary in booklet form. In no way will the Commission findings be released for public information. Space at this time does not permit the full outline of the Anesthetic Study Commission's inner workings. The proposal is to be presented in full at the May meeting in Macon, and through the medium of the Association your approval will be requested. We urge that you become fully acquainted with the proposal and that you give it your wholehearted cooperation.

ABOUT THE HEART PAGE

THE PAST THREE issues of the JOURNAL have each presented something new in the way of makeup or editorial matter. This month the staff of the JOURNAL wishes to draw your attention to the new HEART PAGE in the scientific section. Starting with this issue, the HEART PAGE will be presented each month. Sponsored by the Georgia Heart Association, the articles will be written by Georgia physicians. The articles will be brief and will emphasize the practical aspects of the

latest cardiac information. This new feature of the JOURNAL is being presented through the cooperation of the Georgia Heart Association.

Also this month, we would like to draw your attention to the new Doctor Placement Page which will be found in the back section of the JOURNAL. This page carries a list of physicians seeking locations and a list of communities that are looking for a physician. Further information concerning these lists can be obtained at the MAG Headquarters office.

*Further Observations on the Use of*VAGOTOMY *for Duodenal* ULCER

CHARLES H. RICHARDSON, JR., M.D., Macon

THREE YEARS AGO before this association the choice of operation for gastroduodenal ulcer was discussed and an analysis of operated cases given. The use of vagotomy in duodenal ulcer was briefly compared to the use of subtotal gastric resection. Since there has been considerable controversy on this subject the purpose of this study is to record additional experience in the use of vagotomy and the results to date.²

The material consists of 30 cases of duodenal ulcer treated by trans-abdominal vagus nerve resection combined with gastro-enterostomy. These were operated between January 1949 and January 1953. All have been followed up as closely as possible to date with a recent contact in 28 of the 30 cases and a constant follow up of from one to two years in the other two.

The average age at operation was 43 with a range of 24 to 78. There were seven women and 23 men. Symptoms of gastrointestinal disease had been present from nine months to thirty years averaging around twelve years. At least one gastrointestinal x-ray series had previously demonstrated a duodenal ulcer. Practically all had followed medical regimes of varying strictness without consistent relief. Three had previously had emergency operation for perforation and one had a gastro enterostomy performed in 1918 with several hemorrhages and increasing obstruction since.

Each case was studied by careful examination including gastro intestinal x-rays and a gastric analysis. Many were given a Hollander Insulin Test and often this was compared with alcohol or histamine gastric analyses. Several received additional trials at full medical regulation before surgery was decided on.

The primary indication for operation was obstruction in thirteen, intractability in eleven and repeated hemorrhage in six. Often more than one of these were present. Pain was common especially at night and many existed on a limited diet. A few had regular

vomiting and weight loss. *Intractability* was interpreted as meaning an ulcer which had been demonstrated more than once by x-ray, caused significant pain and disability, and had not responded to an adequate medical treatment. Age alone was not a determining factor. The 78 year old male had an active ulcer, with obstruction and high acid response to insulin tests.

Vagotomy as a surgical method of treating peptic ulcer was introduced in its modern form by Dragstedt in 1943. Its use is based on the physiological and pathological facts that the peptic ulcer patient's stomach puts out more acid and pepsin and that the main secretory fault is an over activity of the cephalic phase through the vagus nerves. Stopping this stimulation greatly reduces this secretion. The premise on which surgery is based for this disease is that reduction of this secretion to a very low level will arrest the disease. Subtotal gastrectomy also reduces acidity but it does so by different means, that is, reducing the source of humoral stimulation as well as a large part of the secreting stomach. That this is not enough is attested to by the fact that in approximately 5 per cent subtotal gastrectomy is followed by recurrence.^{3 4 1 9 14}

There are other objections to gastrectomy as the method of choice. The operation in good hands carries a mortality of two to five per cent. The patient is disabled for several months, many cannot keep their weight and suffer fairly marked digestive disturbances. The unpleasant side effects reduce the satisfactory results to around 85 per cent in many recorded series. This led to the search for a less radical and theoretically more logical procedure.

Considerable early work was done in testing the effects of vagotomy alone. These studies showed that after a complete vagus nerve interruption the ulcer would heal and the gastric secretion would be greatly reduced. However, because of another effect of vagotomy, loss of tone in the stomach, poor emptying and retention would result. Vagotomy has consequently been supplemented by pyloroplasty or gastroenterostomy and its use alone abandoned by

Read before the symposium on gastroenterology, 103rd Annual Session, Medical Association of Georgia, Savannah, May 12, 1953.

most surgeons. With the combined operations various authors report 85 to 90 per cent satisfactory results.^{6 7 11}

In the present series, vagotomy plus gastro enterostomy was first tried in a case with chronic disabling symptoms and x-ray evidence of multiple ulcerations and scarring of the first and second portions of the duodenum. In this type gastric resection carries great danger because of the technical difficulty in closing the duodenal stump. This patient weighed 205 pounds and showed 70 degrees free hydrochloric acid on insulin test. He has been followed over 4 years and has had no ulcer pain since. X-rays show healing and an insulin test post-operatively showed only 10 degrees free acid. He complains occasionally of regurgitation and heart burn but does not need to take medicine for it and is able to work full time. After this first case the combined procedure has been employed in other cases of duodenal ulcer, particularly those with high insulin tests. However, it was found that the alcohol, histamine and insulin tests roughly parallel each other and in no instance was the response to histamine high and that to insulin low. Furthermore no case seen here of duodenal ulcer, with stenosis or not, was accompanied by a low acidity and those with obstruction generally had very high readings.

Technique

The technique of operation used is as follows: a Levine tube is passed the morning of operation. Endotracheal anesthesia is commonly used for good relaxation. High exposure is necessary and originally the midline incision was used. This was later replaced by the high left paramedian rectus splitting incision which gives a stronger wound. The abdomen is explored, the ulcer area inspected, the stomach retracted downward and the left lobe of the liver freed from its attachment to the diaphragm. The peritoneum over the esophagus is opened and the anterior vagus freed, a section removed and the ends ligated. The esophagus is then mobilized all around, pulled down, the posterior vagus stripped out, sectioned and ligated. As the nerves are frequently multiple a careful attempt is made to break the supradiaphragmatic connections and all fibers along the esophagus or in its wall are visualized and divided. The peritoneum is then reunited over the esophagus with one or two sutures. Through an opening in the mesocolon a short loop, posterior, vertical gastrojejunostomy is made in the most dependent part of the stomach. The appendix is often removed if present and the abdomen closed without drainage. This operation usually takes one and a half to two hours, approximately half of the time of gastric-resection. Blood loss is minimal and only an occasional case needs to be transfused. The Levine tube is kept in 48 hours and water begun by mouth on its removal. A Sippy diet is given on the third day and usually the patient eats a full soft diet by the 7th.

Results

The most dramatic result has been the immediate relief of ulcer pain. Many patients report that this was noticed from the time of recovery from the anesthetic. The usual hospital course has been very smooth and the average stay about ten days. About one third had some diarrhea in the hospital. This persisted a few weeks in some but did not remain a problem in any. Most patients now report that their bowels are regular without laxatives. Two patients had respiratory complications, one an acute tracheo-bronchitis and the other a pneumonitis at the left base probably related to mediastinal reaction. Three patients reported mild cardio-spasm for a short while. There were no wound infections although one heavy set male developed a ventral hernia in a midline incision. One patient had a mild thrombophlebitis which responded quickly to conservative therapy. Most patients ate a regular diet in about a month with weight gain the rule. The usual time of return to work was from four to six weeks post-op.

In following up these thirty cases attempt has been made to judge the results both subjectively by a set of questions, and objectively by clinical, x-ray, and laboratory studies. A rating of excellent means that the course of the disease has been arrested and that the patient has remained well and symptom free to date.

Nineteen of the thirty patients fell into this group and have remained so from a few months to over four years. In those checked the insulin tests have remained negative. A number of these patients have continued to smoke and nearly all of them eat anything that they wish.

Six more cases are rated good. This means that the course of the disease has been arrested, that they are able to carry on normal activities but that they have occasional complaints such as heart burn, regurgitation, and occasional GI upset.

Two more patients have been rated only fair. This means that objectively their ulcers have remained healed but that they continue to complain of moderately severe symptoms, usually nervousness, heartburn, and occasional vomiting. These two have definitely been helped by the operation but are symptomatically unsatisfactory. It is interesting to note that the indication for operation, hemorrhage in one and intractable ulcer pain in one, have not recurred post-op.

Three cases are failures and rated poor. Two were resected because of continued pain and suspected recurrent ulcer. Neither had an active ulcer at the second operation and have continued to have more or less severe gastric symptoms for which an organic basis cannot be demonstrated. One of these was the only patient who bled after operation. He was a 24 year old male, operated on because of previous hemorrhages on February 23, 1950. Two weeks post-operatively he vomited a moderate amount of blood.

He was treated conservatively but continued to have gastric symptoms particularly pain. Finally, after several hospitalizations he was reoperated in January 1952, in spite of a very low insulin test. No ulcer was found. He continues to have some symptoms but thinks that he is now better.

Another of these patients was a 25 year female operated on February 15, 1950 because of hemorrhage and failure to respond to treatment. Her post-op insulin test was strongly positive and her pain and vomiting continued. On March 14, 1950 she was re-operated and two additional vagus fibers found and cut. After this her insulin test has remained negative and several x-ray studies have not revealed any new ulcer or activity of the old one. She still complains of choking spells, nervousness and sometimes vomiting. Very recently she has had an antral resection elsewhere, although an active ulcer was not found.

There have been marginal ulcers and no definitely proven recurrences in any of the thirty. Those who have had symptoms have been given repeated x-ray studies and gastric analysis. The insulin tests have remained negative but other types of gastric analysis such as alcohol and histamine show a low normal response. All of the patients are still living although one is very feeble and in an institution for the aged. Most are quite pleased with their results.

Comment

From these thirty cases one may get a representative sampling of complicated duodenal ulcer. Those with chronic severe disabling disease got the most satisfactory result from operation. Perhaps the results could have been improved by not operating on the severely neurotic individuals. However, in these the indications for surgery were just as positive and the need for protection against further complications just as great.

This study confirms the reports, that a high degree of protection against recurrent ulceration and hemorrhage as well as consistent healing in duodenal ulcer can be expected by the combination of vagotomy and gastro-enterostomy. The relief of pain is dramatic and a quick return to normal life is usually to be expected. The side effects of vagotomy are minimal when gastro-enterostomy is added and need not be a real concern. While much easier on the patient, the operation requires good anesthesia and meticulous attention to complete severance of all vagus fibers. Although this operation carries about the same satisfactory result rate as subtotal gastrectomy, it is ac-

companied by far less risk and permits the chronic duodenal ulcer patient to be well and still retain his stomach. There is a great saving to him economically, both in the hospital charges and in the earlier return to normal work.

Analysis of these thirty cases shows a satisfactory result, that is excellent or good, in 25 or a percentage of 83 per cent. The five cases rated fair and poor are considered unsatisfactory and make up 17 per cent. In these five the absence of definite recurrent ulcer, low acid post-op, and severe complaints that cannot be related definitely to organic disease suggests a stronger functional element than is present in many ulcer patients. It is very doubtful if gastric resection employed as a primary operation in these patients would have added much to the result.

Summary and Conclusions

1. Thirty cases of duodenal ulcer surgically treated by vagotomy combined with gastro-enterostomy have been reviewed.
2. Follow-up results to date suggest that the operation is effective in healing the ulcer and gives a high protection against recurrence.
3. Side effects and complications of the operation are minimal.

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"Southern A.M.A. Special"

More than 100 Georgia doctors and approximately the same number from neighboring states have indicated interest in the "Southern AMA Special," being organized to combine attendance at the San Francisco meeting of the AMA in June with an in-

teresting tour through the west.

En route visits will be made to the Grand Canyon, Hollywood and other points in the Southwest and the return trip includes Lake Louise, Banff and spots in Canada and the U. S.

BENTYL HYDROCHLORIDE:

New Methods of Administration and Dosage

CHARLES W. HOCK, M.D., Augusta

THE SYNTHESIS of Bentyt Hydrochloride* was reported in 1947.¹⁵ Pharmacologic studies in animals indicated that the material possesses potent atropine-like effects with respect to gastrointestinal motility but that a strikingly higher dosage is required to influence salivary secretion or size of the pupil.^{1 + 12 3} Inhibition of human gastrointestinal motility was demonstrated by roentgenological means,¹¹ by pressure changes within open rubber catheters placed in different portions of the stomach and intestine,⁹ and by a decrease in morphine-induced biliary tract spasm as indicated by pressure changes within a T-tube.¹⁰

The clinical use of Bentyt in the symptomatic treatment of functional bowel distress was described in 1950⁶ and has since been reported by other investigators.^{11 7 14} Two years later there had been 1,272 consecutive cases reported in which Bentyt had been administered in therapeutic dosage without producing dilatation of the pupil. It had even been used safely in the treatment of digestive disturbances in patients with glaucoma.⁸ Accidental overdosage in a small child who drank the equivalent of nine times the adult dose did not produce sufficiently serious symptoms to require the use of an antidote.¹³

Enteric coated tablets of Bentyt were prepared for use by patients receiving the usual, quick-acting capsules in whom nocturnal recurrence of symptoms might be expected. Return of symptoms requiring medication during the night occurred so rarely in connection with Bentyt therapy that it was not possible to make a valid comparison between the two dosage forms. However, there were some patients in whom the characteristic symptoms associated with gastrointestinal hypermotility were annoyingly present on

awakening. In these patients, the enteric coated material administered at bedtime was generally effective in preventing early morning distress and the spasmolytic effect of Bentyt was prolonged until the usual morning dose had become effective. Preliminary results were so encouraging that it was proposed that it might be possible to maintain patients on enteric coated material even during the day. It was hoped that there would be a substantial period of overlap between the effects of each dose so that the action of the drug would be more sustained and constant.

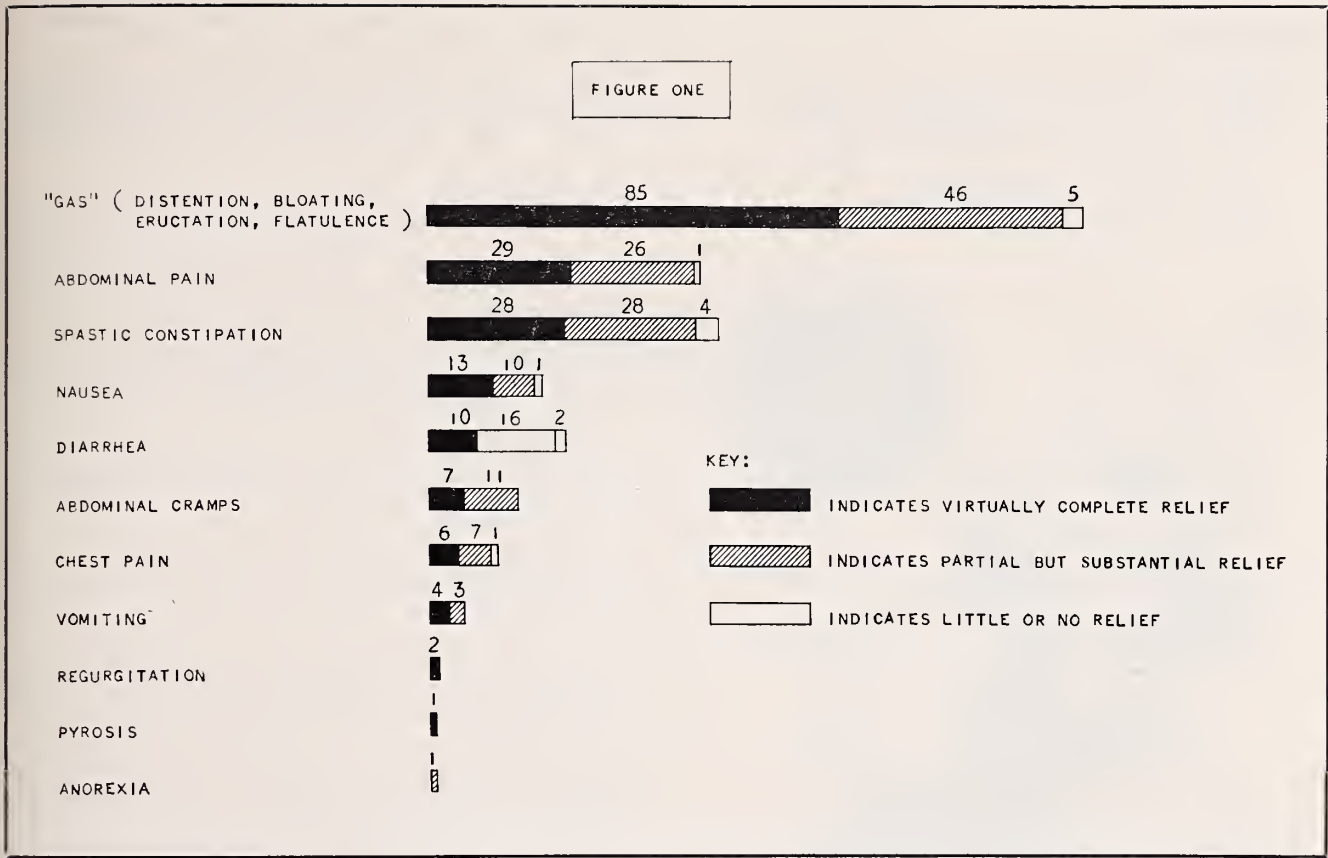
This hypothesis appears to be generally confirmed on the basis of a study of the first 139 patients treated over a period of 24 months with a total of 146,600 doses of 20 mg. each. Of these patients there were 121 suffering from functional bowel distress, frequently associated with other conditions. Peptic ulcer (usually duodenal) was present in 32 of the patients. Less common diagnoses were biliary dysfunction (5), nonspecific ulcerative colitis (4), diverticulitis (2), and one each of the following: diarrhea following resection of the ileum, chronic gastritis, tabes dorsalis, prolapse of the gastric mucosa, duodenitis, regional ileitis, and spasm secondary to rectal carcinoma.

The dosage was adjusted to the individual needs of the patient. The optimum level appeared to be 40 mg. three times daily in 2 cases, 20 to 40 mg. three times daily in 11 cases, 20 mg. three times daily in 103 cases, 20 mg. twice daily in eight cases, and in the remaining 15 cases there was considerable variation in the required dosage.

In Figure One it can be seen that these 139 patients suffered from the usual symptoms of gastrointestinal hypermotility. There was a total of 347 symptoms of which 185 were completely relieved and 148 partially relieved during therapy. Only 14 of the 347 complaints (3.1 per cent) were

Dr. Hock is Assistant Professor of Medicine, Medical College of Georgia, Augusta, Georgia.

*Bentyt hydrochloride is the trade-mark of The Wm. S. Merrell Company, Cincinnati 15, Ohio, for its brand of dicyclomine hydrochloride.



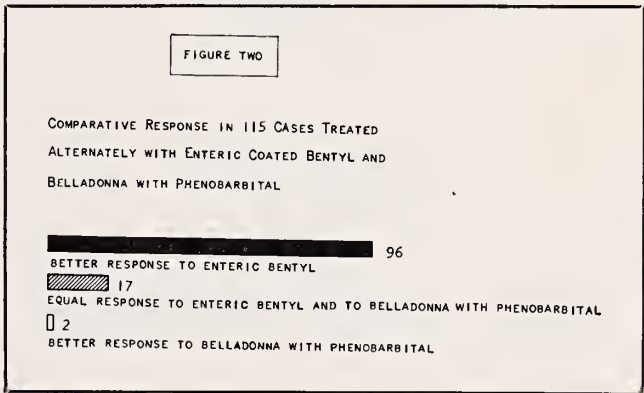
not benefited by the medication. This might be expected in view of the demonstration that Bentyl "either decreased the height of pressure waves or suppressed them completely depending upon the dosage employed"⁹ when it was subjected to pharmacologic study in human beings.

In 115 patients it was possible to compare the response to enteric coated Bentyl without phenobarbital to that of the familiar mixture of belladonna with phenobarbital. In 96 of the patients enteric coated Bentyl produced a more favorable response and the sustained nature of the relief was a characteristic feature. It is noteworthy that even during periods of stress exacerbations of symptoms seldom occurred. There were 17 patients who responded equally to the two test drugs and two who were more comfortable on belladonna with phenobarbital. It is possible that both of these patients might respond better to a combination of Bentyl with phenobarbital than to Bentyl alone (Figure Two).

As previously reported,^{6, 13} Bentyl is singularly free from the tendency to produce side effects upon the eyes and mouth. In this present study no side effects were encountered.

Summary

Bentyl hydrochloride has been administered in enteric coated tablets to a series of 139 patients during a period of two years. The usual dose was 20 mg. three times daily. Sustained relief of a variety of gastrointestinal symptoms was obtained by a ma-



jority of the patients. Because of its long duration of action this form of Bentyl is particularly useful in preventing early morning distress.

Medical College of Georgia

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"Eh? Oh, I never go!"

Says Dr. J. M. Smart, H. & B. D.*

*(Horse and Buggy Doctor)



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Convention of International Academy of Proctology

All physicians are cordially invited to attend the Sixth Annual Convention of the International Academy of Proctology to be held at the Palmer House, Chicago, Illinois, April 8, 9, 10 and 11th, 1954. An extensive Motion Picture Seminar of Proctologic Surgery (including office techniques) will be held on April 11th, 1954. All scientific papers will present the latest developments in proctology and gastroenterology.

Because general practitioners, as well as gastroenterologists and proctologists, face proctologic problems in their daily practice, much of the program has been planned to answer their questions. There is no fee for attendance at the Annual Convention of the International Academy of Proctology. The program will be available in the near future, upon request to the Executive Office of the International Academy of Proctology, 43-55 Kissena Boulevard, Flushing, New York.

HEAD INJURIES

and

PSYCHIATRIC *Sequelae*

JOSEPH D. McELROY, M.D., Atlanta

ALMOST EVERYONE has had blows on the head but in no two instances are the effects the same. Influencing factors include extent and location of damaged tissue, treatment measures, circumstances of injury, including such psychological factors as feelings of guilt or possibility of social or financial gain, the basic personality pattern, and, during convalescence, problems of social and economic natures. The neuropathology and early treatment must be left for consideration by others except for a word about the iatrogenic factor. We all know of people whose invalidism is predominantly the result of conscious or unconscious suggestion involving unwarranted pessimism on the part of the physician. This is particularly important in head injuries because of the many difficulties in establishing an exact diagnosis and prognosis and because of the particular psychological values stemming from the indispensability and vulnerability of the brain.

Circumstances under which the injury occurred are important in various ways. Traumatic neuroses in which the resulting handicap is predominantly functional are more common in war settings and where compensation litigation is involved.

Apart from degree of brain damage, the largest single factor in reaction to head injury is the basic or pre-injury personality. Conversion reactions, such as blindness or paralysis without organic basis, are to be expected in hysteroid personalities who will have a history of breaking down under stress. It is extremely difficult to positively identify the malingerers but by their oft repeated deeds shall ye know them. Compensation neurosis, which may not be a separate entity, is another problem in diagnosis and treatment, the diagnosis often being made in retrospect when the recovery followed liberal salving with green stuff—which is not chlorophyllin. Several other personality type reactions are described in later paragraphs.

We must mention the effects of decreased mental and physical efficiency, attitude of public and family toward the handicapped, expense of prolonged medical care and threatened decrease in standard of living through lessened productivity as also influencing convalescence. This last factor may account for those people who have too little incentive for recovery.

The differential diagnosis and prognosis in head injury often requires a multiphasic approach, including careful past and present history, neurological study, and possibly electroencephalogram and psychological tests. EGG findings must be correlated with clinical findings. Of the psychological tests the Rorschach (Ink Blot Test) is most valid. Rorschach signs of organic brain damage, of which many are comparable to clinical signs, include persistent repetition, perplexity and confusion manifested by distrust of the person's own responses, exaggerated concern about his performance in the test and urgent desire for reassurance. Rorschach signs may be demonstrable before other signs are evident and this test is frequently useful in differentiating out the neuroses. For example, in a compensation neurosis there may be an unusual number of anatomic responses and clinically this is paralleled by a very detailed account of each complaint. The brain damaged person is likely to minimize many symptoms.

The history of any loss of consciousness is of great importance, because if present for as much as 12 hours, subsequent personality changes are more than likely to occur. Most patients are inclined to exaggerate duration of unconsciousness, so we should seek supportive testimony.

In patients with organic brain damage, we find

hypersensitivity to heat, headache, not usually relieved by the common analgesics, vertigo, insomnia, a fluctuating state of fear, greater or lesser intellectual impairment, emotional instability, (as for example brief, explosive crying, possibly followed almost immediately by laughing), short attention span and difficulty in concentration, and irritability. This irritability may be associated with aggressiveness and euphoria. The headache and vertigo are usually aggravated by motion or exertion. The difficulty in concentration may resemble that seen in neurosis but is more constant, and there is a more labile reaction to frustration.

We are all familiar with the picture of the person with extensive cortical damage who may best be described as apathetic and intellectually deteriorated. Lesser destruction permits of a mixture of apathy and explosive irritability which may lead to violence. In moderate damage, the patient may transparently and pathetically attempt to hide from himself and others his intellectual deficit, may compensate with euphoria, and through faulty judgment project himself into complex situations. These persons often belligerently reject advice, reasoning that it represents unwarranted interference.

A 27-year-old white male was seen in March, 1952, with a history of intracranial injury in an automobile accident a year before, resulting in hospitalization until January, 1952. He had adjusted well at home until an impelling desire for independence led him to accept a job as salesman for a printing concern on March, 1952. His opening remarks to me were: "My psychological illness began when I went to work. People on the street think I'm intoxicated. I tell them something was wrong with me but that I'm alright now. I want to be treated like any other normal person." He complained of having been unable to sleep and said, "I've worried my mother so much she can't sleep either. She worries about me because she thinks I'm not right and I know I am." He explained periodic shouting was a habit arising from efforts to make his family understand his feelings but went on to say that he could think better and see better when he closed his eyes. Throughout the interview he cried without appropriate stimulus, constantly sought reassurance, and was at times inappropriately euphoric. He was aware of hesitancy in speech, of some difficulty in concentrating, and of pronounced anxiety. It was significant that while he was somewhat aware of emotional tension he insisted that he had "licked the battle psychologically" by visiting one of the hospitals and "acting normal—like I hadn't had an accident." There was a strong element of guilt and apprehension relating to the fact that his companion at the time of the accident was a married woman who was seriously injured. Despite efforts to effect an extramural adjustment, hospitalization became necessary because of rapidly increasing agitation. In the sanitarium he was cooperative with the physician but at times was belligerent, banged his head against the wall, fought the attendants, was extremely noisy and required unusual quantities of Paraldehyde in order to rest at all. The family finally acceded to recommendation for institutional care.

The following notes to the physician illustrate some of the mental mechanisms: "Please tell me why I'm in this condition? I think it is purely mental. I'm as human as anyone, am I not? I am as humble as a human can get, am I not? Is it because of my trial that has not yet happened? Sir, do I have an 'anxiety complex'? If I'm to live, I must know at once? To my way of thinking, God performed a miracle when he saved my life after the automobile accident. I think more clearly because I am in this sanitarium. Sir, I am so humble at this point I am not responsible for what I may say."

The role of trauma in the etiology of convulsive disorders is well known. It has been estimated that more than 30 per cent of persons suffering penetrating head injuries will develop epilepsy within 2 years and another 10 per cent within 3 years. The epileptic personality is characterized by irritability, a sense of shame about the seizures, insecurity directed toward social and occupational adjustments, fear of hereditary influence, and fear of the seizures themselves.

The case of a 40-year-old female is fairly typical:

"I'm about to go crazy. At least, I feel like it. Everything's wrong—husband who won't work, won't try, we're in debt, and it's about to run me crazy depending too much on my people. I've done my share with what little money I had, and it's about gone. I've been a mighty sick girl; was in the hospital; everybody thought I was going to die. Had brain concussion and had an operation, and when I came out my head was shaved, and I didn't even know where I was. Couldn't see, and ever since I've been a nervous wreck. I can't work. Don't sleep good; awake every 2 or 3 hours. We get up some of the craziest things to fight about. Got to the place where I don't care what happens to me; don't want to be in anyone's way; it would have been better if I had died."

Her husband contributed somewhat to the picture:

"An awful sweet wife. She fell last fall, was in the hospital. I usually give in to her on everything, as far as I can. She wants the car keys, I won't give them to her, then first thing I know she jumps in the car with the keys and off she goes. I suppose she gets mad, says 'I'll just pack up your things and let you go ahead and live by yourself, that's what you want.' Next day she was just as humble as could be. We went to church, and she wanted to be reborn. It's just those times that I don't know what to expect, or what's going to happen. She has spells, passes out for a couple of minutes. Then right after that, she'll do most anything I tell her. Then right after those spells, that's when she gets in that mental state. She tells stories, and I don't even try to stop it, because if I do, she wants to go to fighting again."

The psychopath tolerates head injury poorly, and both family and patient are inclined to exaggerate any organic feature. He is an example of the possibility that the emotional effect can far exceed the effect of organic brain damage. By way of parenthesis, the psychiatrist soon learns to be wary of claims of amnesia, particularly with those in trouble with the law.

In the case of a 22-year-old white male, at his first psychiatric examination, history indicated that this man received a head injury at age eight. There was no history of convulsive seizures. Due to poor learning progress, he was transferred to an ungraded class after the sixth grade. Shortly thereafter, the patient was first sentenced to a correctional institution. However, antisocial behaviour existed prior to this time. For example, at the age of eleven he ran away from home. Since the age of fifteen he had spent no more than four or five weeks at a time outside of some penal institution. He has committed various offenses, claims to have no memory for any of these offenses and claims total amnesia for the offense of armed robbery currently pending. In each instance of alleged amnesia, he would have it appear that the amnesia began shortly prior to the offense and terminated shortly after the offense. No evidence was presented indicating amnesia over periods which were not of such a nature as to place him in legal jeopardy.

Excerpts from his remarks follow:

"They got me accused of robbery. I just don't remember what happened. Have blacked out before; don't know how many times; remember talking to a girl, then nothing until in jail about 2 hours later; don't remember having a gun. Will average a blackout about 3 or 4 times a year, if out in the air. After it's over it's like something hitting me in the head (headache). Headache nearly every week, for 3 to 4

hours to all day. At times a feeling of fire or ice going up and down the spine; things get dark, then I have to sit down; have 1 or 2 a month. Nervous at times—am jumpy, “funny.” I’m OK after getting to sleep with a little bit, not much, trouble. different things they’ve had on me, all on account of going out of my head; they say they’ve had me on larceny and burglary; I don’t remember doing none of those things.

I believe the first was in 1943, I don’t know. I’ve been out a little over a month working regularly as a brick mason. On the shooting charge, I remember having a gun but I can’t say I shot him. They’re trying to drag me in on a kangaroo court, and I got out the day before it started. They claim we were trying to saw out, day before yesterday; I ain’t seen a saw in 6 months. I know I’ve needed something done for my head; Mother has been telling me for years, but I’ve kept putting it off.”

Alcoholics and arteriosclerotics often show profound changes in personality after cortical damage. These conditions seem to aggravate the symptoms associated with the post-traumatic personality in general, and the patients are prone to overcompensate for their handicap to the degree of paranoia. It seems that this trend of euphoria and projection has something in common with the group who suffer paralysis as a result of destruction of motor areas. It must be noted that persons with any brain disease tolerate alcohol very poorly. At the risk of dangerous brevity and because the alcoholics and sclerotics are particularly liable to cerebral vascular insults, either traumatic or spontaneous, these groups will be considered together as exemplified in the following case:

A 45-year-old white male, with a history of excessive use of alcohol since late adolescence, and many falls and fights, suffered a stroke involving the right side at age 41. Following his stroke, he became increasingly irritable, demanding and threatening. He continued to drink until he had a seizure in church two years later. He became extremely jealous and criticized his wife for being slovenly and of resenting his partial recovery, and became extremely unstable emotionally. On several occasions he threatened the life of his wife, apparently on the basis of delusions of infidelity, and on a number of occasions he contemplated suicide. Following admission to a sanitarium for psychiatric evaluation, in connection with an appeal from commitment by a lunacy commission, he complained that hospitalization was part of a plot to confiscate his estate. He asked to be returned to jail to save expenses and stated that since he had had a good time in his life, he was ready to die for his principles. There was much paranoid rambling in relation to his wife, “the farce of the lunacy hearing,” and toward those who had failed to agree

A.M.A DUES

Any Georgia physicians who have been dropped from A. M. A. membership because of nonpayment of 1950 dues, have been granted a reprieve until July 1, 1950. According to a resolution adopted by the House of Delegates at the A. M. A. meeting in St. Louis, “any active member of the American Medical Association who failed to pay dues for the year 1950, and who was suspended for such delinquency, may be reinstated during the first six months of 1954 by payment of 1954 dues only. Should such an individual fail to pay his 1954 dues by July 1, 1954, he shall continue to be considered delinquent.” The resolution will be effective only to July 1, 1954; after that date such members will again be held liable for the payment of 1950 dues if they wish to be reinstated to active membership.

with him. Explosive outbursts of crying were frequent, usually when speaking of his wife. He said, “The only reason I am here is the headstrong, ignorant domination of my wife.” Although he was aware of very limited use of the right extremities, there was a continuing effort to conceal his handicaps and frequent assertions that he could do anything which was formerly within his ability.

Summary

We have considered some of the reactions to head injury and brain damage. Other types are omitted because of relative infrequency. In summary we may say that psychiatric sequelae of head injury vary in accordance with a number of factors; more or less in order of importance: type, location and severity of brain damage and residuals, the basic personality, present environmental factors, incentives for recovery or other gains, and circumstances surrounding the injury.

Doctors Building

New Orleans Graduate Medical Assembly

The seventeenth annual meeting of The New Orleans Graduate Medical Assembly will be held March 8-11, headquarters at the Municipal Auditorium.

Eighteen outstanding guest speakers will participate and their presentations will be of interest to both specialists and general practitioners. The program will include fifty-four informative discussions on many topics of current medical interest, in addition to clinicopathologic conferences, symposia, three dimensional surgical motion pictures, round-table luncheons and technical exhibits.

The Assembly has planned another interesting postclinical tour to follow the 1954 meeting in New Orleans. On Sunday, March 14, the group will leave Los Angeles via Pan American World Airways and accommodations have been secured at the Royal Hawaiian Hotel in Honolulu, Island of Oahu.

Details of the New Orleans meeting and the post-clinical tour are available at the office of the Assembly, Room 103, 1430 Tulane Avenue, New Orleans 12, Louisiana.

OSTEITIS CONDENSANS ILII

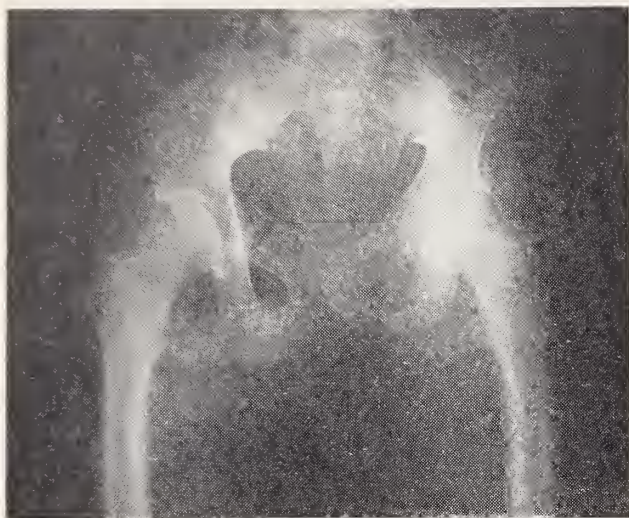


Fig. 1. Radiological features in a case of rheumatoid spondylosis. Note involvement of both sacrum and ilium with obliteration of joint space.

OSTEITIS CONDENSANS ilii is a sclerosing lesion involving the ilium adjacent to the sacroiliac articulation without involvement of the joint or sacrum. The condition is diagnosed only by properly executed radiographs. There are no consistent clinical features, and the clinical significance of this finding is debatable.

A review of the literature reveals that only approximately 110 cases of osteitis condensans ilii have been reported. Recently, we have encountered this condition in two cases which, clinically, were lumbar disc suspects. It is our purpose to review briefly some of the pertinent facts about osteitis condensans ilii and to present two cases which demonstrate the clinical similarity between this condition and herniated nucleus pulposus.

Historical Data

Advances in x-ray technological skill and interpretation made the discovery of this osseous lesion possible. Sicard, Gally and Haguénan⁶ first described a sclerosing bone lesion in 1926 and presented five cases. They, however, did not limit the osteitis condensans to the ilii. In 1928, Barsony and Polgar¹ stated that the sclerosing bone lesion was confined to

the os ilii and they referred to the condition as "osteitis condensans ilii." They observed 15 cases during a period of one and one-half years.

Etiology

The etiology is still uncertain. Berent,² in 1932, reported three cases which he felt were related to trauma incident to childbirth. Rendich and Shapiro⁵

Report of Two Cases Simulating

felt that the type of lesion suggested a low-grade inflammatory process. Ude⁸ reported six cases of osteitis condensans ilii which had changes in the spine consistent with residuals of juvenile epiphysitis. His impression was that osteitis condensans ilii represented secondary sclerosing changes superimposed on juvenile epiphysitis. Hare and Haggart³ felt that the changes were due to trauma with interference of the blood supply to the inferior margin of the ilium near the sacroiliac joint. However, the history of any trauma is frequently absent. Szabados⁷ reported three cases associated with urinary tract infection. He pointed out the anatomical relationship between the ureters and the involved bone.

Pathology

A biopsy was taken from one of the patients reported by Rendich and Shapiro.⁵ This is the only record of any histo-pathological study. There was marked condensation of the osseous tissue with obliteration of the lacunae. There was no cellular activity and no evidence of any inflammatory process. There were deposits of lime salts which occurred more or less parallel to the lamellae of bone. This examination gave no clue as to the pathogenesis of the bony lesion.

Incidence

Knutssen⁴ stated that the sex was female in 35 of his 37 cases. Hare and Haggart³ stated that the sex was predominantly female with the average age of 30. Szabados⁷ showed the average age in the three cases he reported to be 49 and all were females. Ude⁸ reported six cases, five of which were females and one male. The average age was 42.

Symptomatology

Rendich and Shapiro⁵ felt that it is important to avoid ascribing clinical significances to a condition that may be only an incidental roentgenographic finding; however, most of the cases reported presented symptoms referable to the low back. In many instances, the low back pain had been present for a number of years and was intermittent in character. Sometimes, the pain is unilateral with radiation of the pain into the hip and down the leg. The pain is frequently aggravated by bending and lifting and usually some relief is obtained by lying down. The physical findings are usually not very specific, including such findings as mild to moderate lumbar muscle spasm, some limitation in bending, and tenderness to palpation over the involved region. There is usually no suggestion of any nerve deficit; however, in the series reported by Hare and Haggart,³ four cases were diagnosed as having herniated discs and one of these was operated upon without relief of symptoms.

iated Nucleus Pulposus

Laboratory Data

No consistent laboratory findings have occurred in this condition. Routine blood and urine examinations are usually normal. The erythrocyte sedimentation rate is routinely within normal limits; as contrasted with a consistent rise in rheumatoid spondylosis (Marie-Strumpell). There is no disturbance in the blood calcium-phosphorous ratio nor in the phosphatase level.

X-Ray Features

Rendich and Shapiro⁵ give an excellent description of the x-ray findings: "Characteristically in this condition, there occurs a zone of markedly dense bone in that portion of the ilium adjacent to the sacroiliac synchondrosis; usually, the involvement starts near the most inferior portion of the joint. It may be limited to a very small area, several millimeters in diameter, or it may involve the entire extent of the ilium as it adjoins the sacrum. The area may be sharply demarcated from the surrounding normal bone or it may gradually merge with it. On the usual negative, it appears as if that portion of the roentgenogram had been underexposed, as pointed out by Barsony; no trabeculae nor bony structures are visible in the involved area. On a purposely overexposed film, however, the bony trabeculae may be seen to be thickened and irregular. The lacunar spaces appear as if filled with a greater calcium deposit than usual, and the entire involved zone has a uniformly opaque appearance. The sclerosis ends very abruptly at the sacroiliac joint. The outer border of the lesion fades somewhat more gradually into the normal iliac bone. The sacroiliac joint proper never shows any evidence of involvement. The joint space

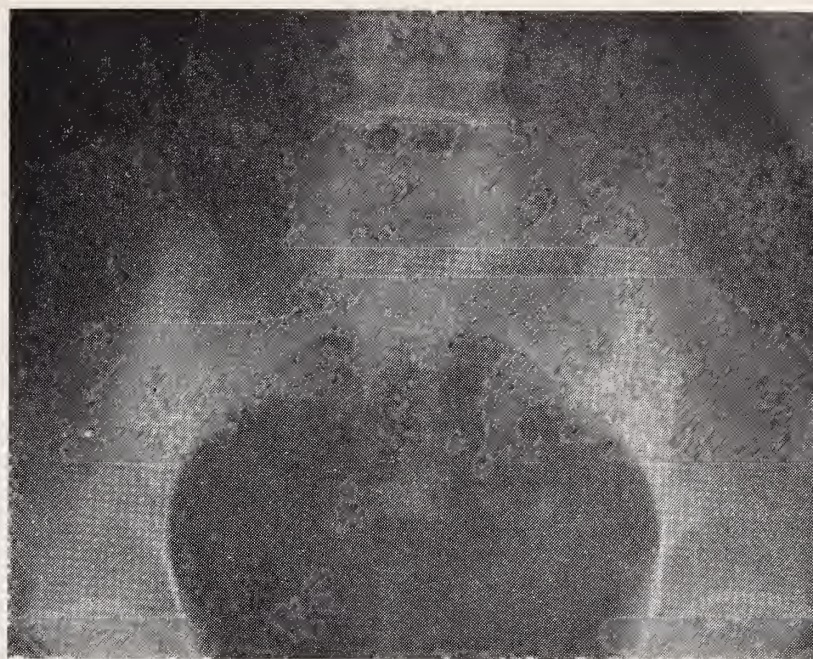


Fig. 2. Case No. 1. Osteitis Condensans Ilii.

is clear, is of normal width, and presents no irregularities of the articular surfaces either on the iliac or on the sacral side."

The condition is usually bilateral. It is the feeling of most authors that only the ilii are involved and that there is no multiplicity of osseous involvement.

X-ray examinations should be performed in the anteroposterior, tangential, and both 45-degree oblique views to clearly outline the sacroiliac joints.

Differential Diagnosis

Since osteitis condensans ilii is altogether a radiological diagnosis, the differentiation is made from the characteristics of bony lesion as shown on the x-ray film. The major condition to consider in the differential diagnosis is rheumatoid spondylosis (Marie-Strumpell arthritis and Morbus Bechterew), (Fig. 1). In the fully developed case, the diagnosis is not difficult since the later condition shows involvement of the sacroiliac joints with fusion of these joints as well as the changes in the spine. In the borderline cases, as pointed out by Knutssen,⁴ a lapse of time may allow a diagnosis to be definitely established. Further, the erythrocyte sedimentation rate is usually increased in Marie-Strumpell whereas it is usually within normal limits in osteitis condensans ilii. Also, Marie-Strumpell is a disease primarily of the male; osteitis condensans ilii of the female.

There are other bone lesions that should be considered, but which can usually be satisfactorily excluded by careful x-ray examination and other laboratory tests. These include bone syphilis, Paget's disease, sclerosing osteomyelitis, tuberculosis, and osteoplastic types of metastases.

From the clinical point of view, the differentiation would include those conditions that are responsible for low back pain, such as lumbo-sacral strain,

spondylolisthesis, arthritis, and lumbar disc. Since there is no definite clinical picture in osteitis condensans ilii, the differentiation must come from the roentgenologist.

Case No. 1

This 27-year-old white woman gave a history of intermittent low back pain with radiation of the pain into the right hip for the past ten years. The episodes of pain have always been brought on by lifting and straining. Prolonged standing and coughing aggravate the complaint. She has noted considerable relief from lying flat on a hard bed and applying heat to the back. For about a month prior to our examination, the pain radiated down the right leg in the posterior lateral aspect to the lateral aspect of the foot. There was no history of any injury to the back.

Her treatment has included a back brace which has helped relieve the back pain, but, apparently, has made the leg pain more severe. Her past history is not significant except for right-sided kidney stones which were removed in April, 1948.

On examination, this was an obese, young woman who appeared older than her stated age. The general physical examination was essentially normal. There was some flattening of the lumbar curve. Bending was limited in all directions, but she could bend better toward the left than toward the right. Straight leg-raising was positive at about 40-degree elevation, and there was a positive Lasegue's sign on the right. There was no weakness of the legs. The reflexes were brisk and bilaterally equal. There was an area of hypalgesia on the dorsum of the right foot and extending up the postero-lateral aspect of the leg to about two inches above the knee. She walked with a limp favoring the right leg.

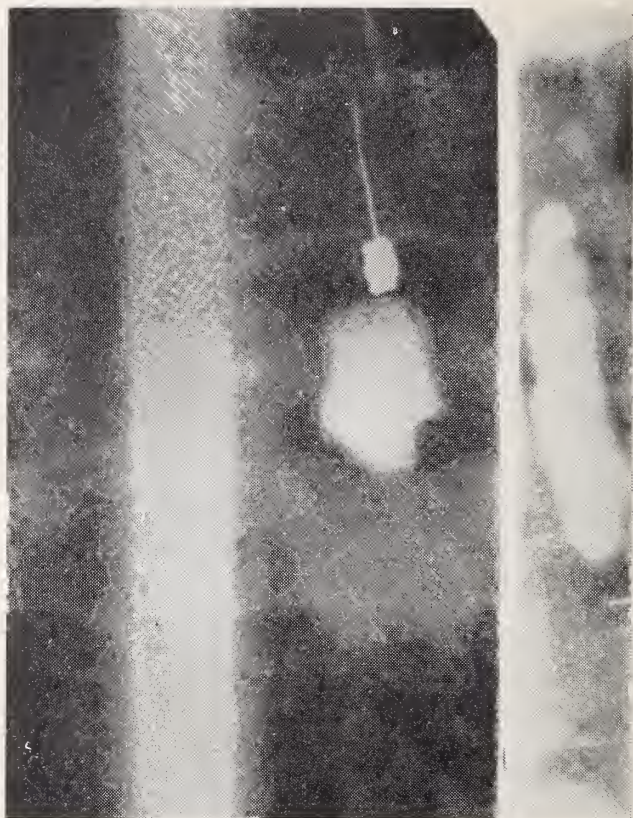
X-rays of the lumbo-sacral spine (Fig. 2 and 3) revealed osteosclerosis of the ilii adjacent to the sacroiliac joint without involvement of the joints or sacrum. No abnormalities were noted in the lumbar spine.

Myelographic studies revealed an asymmetry of the lumbar spinal canal at the 5th lumbar interspace. (Fig. 4). The nerve sleeve was blunted and appeared to be cut off rather abruptly on the right side. The other lumbar interspaces



Fig. 3. Oblique view of Case No. 1 to show preservation of joint space.

Fig. 4. Case No. 1. Pantopaque myelogram with oil at fifth lumbar interspace, showing blunting of nerve sleeve on right side.



appeared entirely normal. Routine blood and urine examinations were within normal limits. Analysis of the spinal fluid was entirely normal.

Correlating the physical findings with the myelographic findings, we felt that this patient had a herniated disc. A hemilaminectomy was done with an exploration of the 5th lumbar interspace on the right side. An unusually large amount of extradural fat was encountered. Careful examination of the interspace failed to reveal any herniated disc. A specimen was taken of the fat which showed no abnormalities on pathological examination.

The patient continued to have complaints following surgery. She was then begun on anti-arthritis drugs without any dramatic benefit.

Case No. 2

This 35-year-old white woman gave a history of recurrent backaches since sustaining an injury to her back thirteen years previously. Because of this complaint, she has been examined by many doctors, and on a number of occasions, the diagnosis of herniated intervertebral disc has been made. At the time of our examination, the pain was located in the low back, right hip, and right flank, with radiation down the right posterior leg. It began after a period of bed rest of 20 hours' duration because of a headache.

The positive findings revealed a positive straight leg-raising test on the right side with a positive Lasegue's sign on this side. There was considerable limitation of motion of the lumbar spine and there was point tenderness at the 5th lumbar interspace. There was also considerable tenderness in the right lower quadrant near the scar from a McBurney's incision. There was an area of hypalgesia on the lateral aspect of the right foot and ankle. The reflexes in the lower extremities were normal. There was no weakness of the lower extremities.

Routine blood and urine examinations were normal. Intravenous pyelograms were normal. The x-rays of the lumbo-sacral spine revealed a condensation of each ilium near the sacroiliac articulation suggesting osteitis condensans ilii. (Fig. 5.) The lumbo-sacral spine appeared entirely normal except for some flattening of the lumbar curve.

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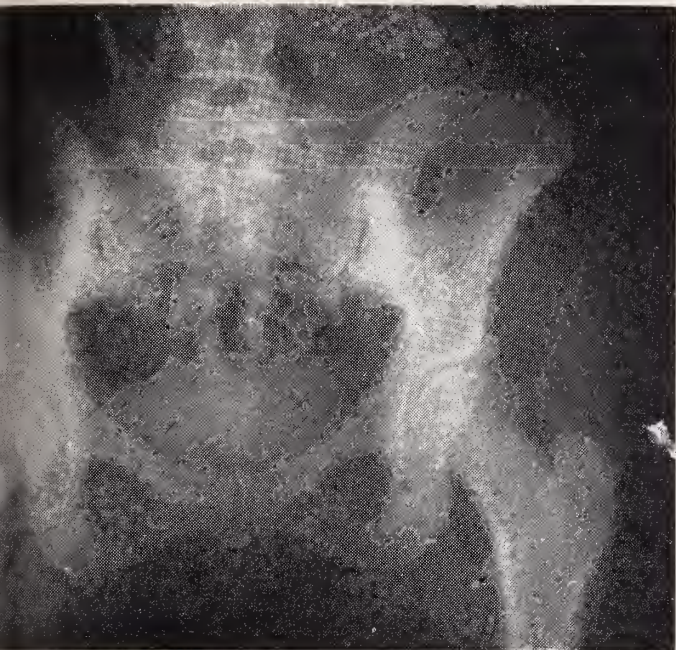
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(NAPHAZOLINE HYDROCHLORIDE CIBA)

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Fig. 5. Case No. 2. Osteitis Condensans Ilii.



Although this lady presented findings very suggestive of a herniated lumbar disc, we accepted the sclerosing lesions in the ilii as being responsible for her symptoms. She was treated conservatively with bed rest and mild analgesics and showed some improvement while under our observation.

Discussion

Both of our cases presented evidence of sciatic nerve irritation as demonstrated by the positive leg-raising tests. Also, both cases displayed sensory deficits. Neither had any motor nor reflex disturbance. The history in both cases is quite compatible with a disc lesion.

In contrast to the previous reports, our cases do show abnormal neurological signs. Accordingly, osteitis condensans ilii, rare as it may be, should be a consideration in lumbar disc herniation suspects.

Summary

1. A brief review of the literature concerning osteitis condensans ilii is presented. The features concerning etiology, pathology, and symptomatology are noted. The x-ray features of this condition are given with the differential diagnostic consideration.

2. Two cases are presented showing the clinical similarity between osteitis condensans ilii and herniated lumbar disc.

P. O. Box 394

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Pelvic EVISCERATION

for Advanced

CARCINOMA *of the* CERVIX

SAM A. WILKINS, JR., Atlanta

THIS REPORT is based on the experience of the author and his associates, Dr. J. Elliott Scarborough, Jr. and Dr. Robert L. Brown, in the Winship Clinic, and the author's previous observation and experience over a 4-year period at Memorial Hospital in New York City, where and while Dr. Alexander Brunschwig began his intensive attack on the problem of advanced pelvic cancer. The study at the Winship Clinic was undertaken in an attempt to gain further evaluation of what extensive surgical treatment had to offer a group of otherwise almost hopeless patients.

Problem

Among women, cancer of the cervix is second only to breast cancer as a killer and accounts for 15 to 20 per cent of deaths from cancer. Hardly 30 per cent of all women found to have cancer of the cervix in 1947 are alive today (Table I). Thirty per cent of cases even in an early stage (Stage I) of cancer of the cervix, do not survive five-years and practically all the patients in an advanced stage (Stage IV) fail to survive five years. These results represent the best that can be accomplished with irradiation alone.

CURABILITY: CA OF CERVIX (Andrews et al., Bowman Gray)		
STAGE	NO. OF CASES	% 5 YR. CURES
I	1700	64.8
II	3168	44.1
III	4136	25.5
IV	1035	5.8
TOTAL	10,039	36.0

TABLE I

These data represent the combined experience of the major institutions reporting their results. The five-year cure rate for the country at large is under 30 per cent.

From the Robert Winship Memorial Clinic, Emory University Hospital, and the Department of Surgery, Emory University Medical School, Atlanta, Georgia.

Study of autopsy material has shown that approximately 65 per cent of women who die from cancer of the cervix die from uremia and infection due to manifestations of the disease or its treatment within the pelvis. About 50 per cent of the patients dying from cancer of the cervix are found to have no evidence that cancer has spread beyond the pelvis. It was because of the discouraging mortality of cancer of the cervix even with the best possible treatment by irradiation and the tendency of the malignant process to remain localized to the pelvis even in a large percentage of cases that Dr. Brunschwig turned his attention to an adequate surgical attack on the problem. He felt that the use of antibiotics and the employment of new surgical techniques would make possible wider surgical excision with a reasonable mortality, and a chance of cure where previously even more limited procedures, such as a radical hysterectomy as performed by Wertheim, Schauta, Bonney and others, had carried a mortality of 30 to 40 per cent.

Historical

Appleby in England probably performed successfully the first complete pelvic evisceration in 1943, when he did an abdominoperineal proctocystectomy with reperitonealization for cancer of the rectum in a male. For many years he had studied the problem of the transplantation of the ureters to the bowel. He had transplanted the right ureter of a baby with extrophy of the bladder and a non-functioning left kidney to the cecum and the patient had survived 22 years only to die from trauma. When he reported his work in 1950, he had six cases, all carcinoma of the rectum invading the bladder. He had an operative mortality of 16.6 per cent and reported four patients living and well seven, five, four and a half, and four and half years after operation. Bricker in St. Louis performed total evisceration for cancer of the cervix as early as 1940, but without success.

It is Brunschwig, however, who deserves the credit for giving impetus to the investigation of the technique of pelvic evisceration and establishing the procedure beyond the experimental stage. Parsons in Boston, Brintnall in Iowa City and Bricker in St. Louis have all made major contributions to the study of this extended surgical procedure.

Technique

Many of the technical obstacles which faced early investigators of the problem have been overcome or minimized. The technique of the rapid replacement of blood is no longer a major problem. Trincer and his associates at the Emory University Hospital made a major contribution in their work on intra-arterial transfusions. The management of electrolytes, particularly the addition of potassium salts to our armamentarium, has contributed much toward the reduction of the morbidity and mortality. The management of infection is now possible to a degree which we did not conceive even ten years ago. Reperitonealization of the pelvis, which at first was thought to be essential, has been shown to be unnecessary, as well as impossible or impractical in most extensive surgical procedures. And much has been learned concerning the transplantation and management of the divided ureters.

The contribution of improved anesthesia to the reduced morbidity and mortality of extensive surgical procedures has been great. The use of blood pressure-depressing agents to produce acute hypotension and minimize blood loss during extensive operative procedures has been and is being studied. In certain unusually difficult situations where bleeding is almost impossible to control, these agents should be of value. But if the procedure can be completed satisfactorily otherwise, it would be more advisable to maintain the patient's blood pressure at a more nearly adequate level.

The procedure is now done generally through a midline incision although some operators use a transverse incision across the lower abdomen. As soon as it seems clear that the procedure can be completed, the peritoneum is opened on each side of the pelvis near the point at which the ureters pass over the brim into the pelvis. The ureters are identified and the peritoneum near them opened down to a point as close to the suspected disease as seems safe and the ureters then divided. Some operators leave a strip of peritoneum attached to the ureter, feeling that it helps to maintain a better blood supply. It has been generally shown that the blood supply of the ureter comes chiefly from the ends and very little is derived from vessels along its route. This strip of peritoneum may help to protect the ureter and may be of some advantage when a portion is sutured over the site of implantation of the ureter into the bowel. After the peritoneum is incised around the brim of the pelvis, the lymph-bearing tissue over the common and external iliac vessels is dissected free and the dissection carried into the pelvis downward along the posterior and lateral walls. The internal iliac and hypogastric vessels are ligated and divided and as the dissection is carried deeper into the pelvis the various branches of these vessels extending into the wall of the pelvis are ligated and divided. With care the venous plexuses about the hypogastric vessels can be controlled and

the sciatic nerve roots completely denuded. After the specimen, including the rectum, vagina, and bladder, has been freed down to its attachment to the floor of the pelvis, the rectum, vagina and urethra may be amputated at the pelvic floor if there is no extension of disease on or near the levators, or the entire specimen may be removed en bloc with a large ellipse of perineum subsequently during a perineal phase of the procedure. If there is extension of disease onto the levator muscles the perineal phase is essential; most workers agree, however, that if the perineum can be preserved safely both the morbidity and mortality is reduced.

The colostomy and the ureters are handled in a variety of means and the number of different techniques probably indicates that none has overwhelming advantages. Some surgeons implant the ureters into the sigmoid and create a sort of cloaca; others prefer cutaneous ureterostomies and still others feel that the better solution is transplanting the ureters to an isolated segment of the ileum and cecum. Another technique is now being used for isolation of the terminal segment of sigmoid into which the ureters have been transplanted. A loop of sigmoid, descending colon, or even splenic flexure is simply brought out over a glass rod via a stab wound and at a second procedure the proximal end of the terminal loop is closed. This last technique has the advantage of simplicity and keeping the operating time to a minimum. In addition, it may easily be applied at a subsequent time after a "cloaca-like" colostomy has been done to convert the colostomy to a dry fecal one and to leave the ureters in an isolated segment of bowel. Most workers now are in agreement that a mucosa-to-mucosa anastomosis of the ureters and bowel with a second layer of supporting sutures is preferable to the various other techniques of anastomosis. The incidence of ascending urinary infection and obstruction with hydronephrosis and renal damage has been considerable. These complications have been more frequent when the ureters have been implanted into bowel above a functioning sphincter where back pressure is greater. The results also appear to indicate that there is greater complication when the ureters are implanted into a functioning colostomy.

Supportive measures used in the pre-operative and post-operative care should include thorough cleansing of the bowel pre-operatively, the maintenance of proper electrolyte balance, the correction of anemia by transfusions as indicated, and the judicious use of antibiotics and sulfonamides. The details of management of these patients are not to be discussed here.

Material

It seemed to us that this procedure had advanced beyond the experimental stage and was ready for clinical investigation in certain institutions particularly equipped for such surgery. It seemed that we were

		RESULTS: PELVIC EVISCERATION				
	AGE	LESION	PREVIOUS TREATMENT	PRESENT ACTIVITY	TIME SINCE OPERATION	STATUS OF DISEASE
N. Z.	48	Sq. Ca. Gr. I-II	Repeated radium Rx 6 mos.	Working part time	25 mos.	Free of disease
G. M.	28	Sq. Ca. Gr. II	Hyst. Irrad. Reop.	Deceased	Died 9 mos. after operation with disease	
M. C.	38	Sq. Ca. Infilt.	Hyst. Irrad.	Working	17 mos.	Free of disease
D. L.	36	Sq. Ca. Gr. III	Oophor. Irrad.	All house work	16 mos.	Free of disease

TABLE II

All of these patients had complete removal of the pelvic viscera. In one patient (D.L.) the perineum was also sacrificed.

presented with an adequate number of cases of advanced cervical cancer to justify our undertaking the problem. While we were seeing on the average only 45 new cases of cancer of the cervix yearly, a good percentage of these cases represented moderately-advanced and advanced disease. Many were problems of advanced cancer referred primarily and purely as problems.

Since the study was begun in May of 1950, 139 new cases of cancer of the cervix have been seen. A very high degree of selection has been exercised, and, as a result, only four patients have been subjected to total pelvic evisceration. Four have been explored but found to be inoperable on the basis of several reasons. Limited procedures have been carried out as palliative measures in several cases and with a number of patients, perhaps 10 or 15, we were able to satisfy ourselves that even exploration was not justified.

In general we have felt that the procedure was of such magnitude and the social and economic problems so great that its application as a palliative measure was not justified except perhaps in occasional instances. Usually we have felt that advanced age, 60 and above, precluded total pelvic evisceration.

Results

Of the four patients who were subjected to total pelvic evisceration three are living and well after two years, 17 months and 16 months. (Table II). One patient who died 9 months after her procedure from recurrent disease had had two previous limited surgical procedures before it was realized that her disease was out of control. There has been no hospital mortality in this series.

Of the three patients who are living none has evidence of active disease. Two apparently are living fairly normal lives and manage their colostomies satisfactorily. (Fig. 1). The third complains of considerable difficulty with the management of her colostomy but is not bothered to the point that she is willing to bring herself to the hospital for help. Of two patients who have had intravenous urography 16 months after their procedure, one has one normal

kidney and one with moderate hydronephrosis. The other has moderate hydronephrosis on one side and slight hydronephrosis on the other.

In this series of operative patients we have had a reasonable number of complications. Even under the best circumstances when one attempts surgery of this sort, one must be prepared to accept complications. The wounds are all potentially infected and sometimes part of the healing must be by second intention. Particularly if the perineum is sacrificed one

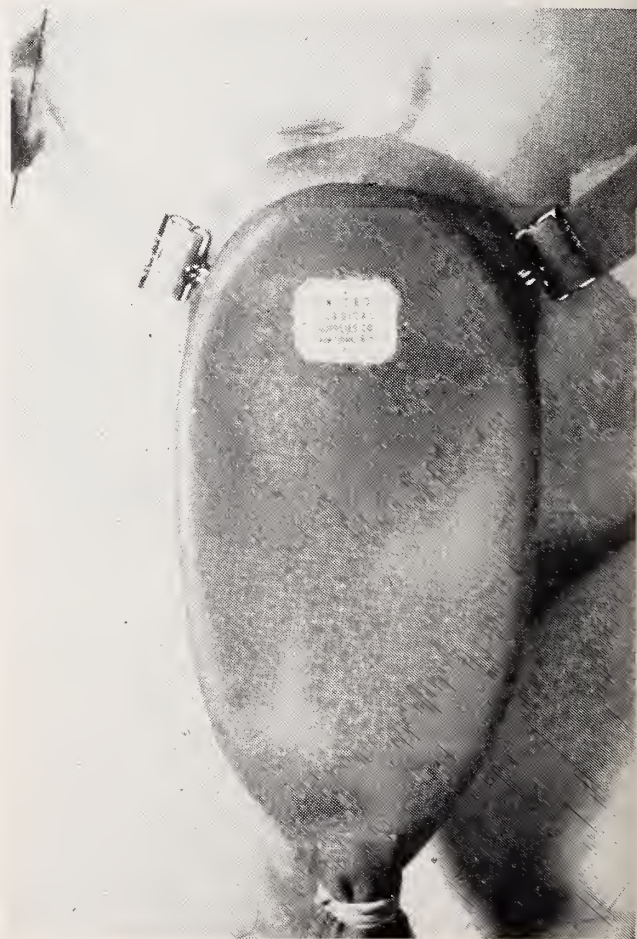


Fig. 1. The Pierce bag worn by this patient has been fairly satisfactory. It has a wide flat flange which is glued to the skin around the bud of the colostomy.

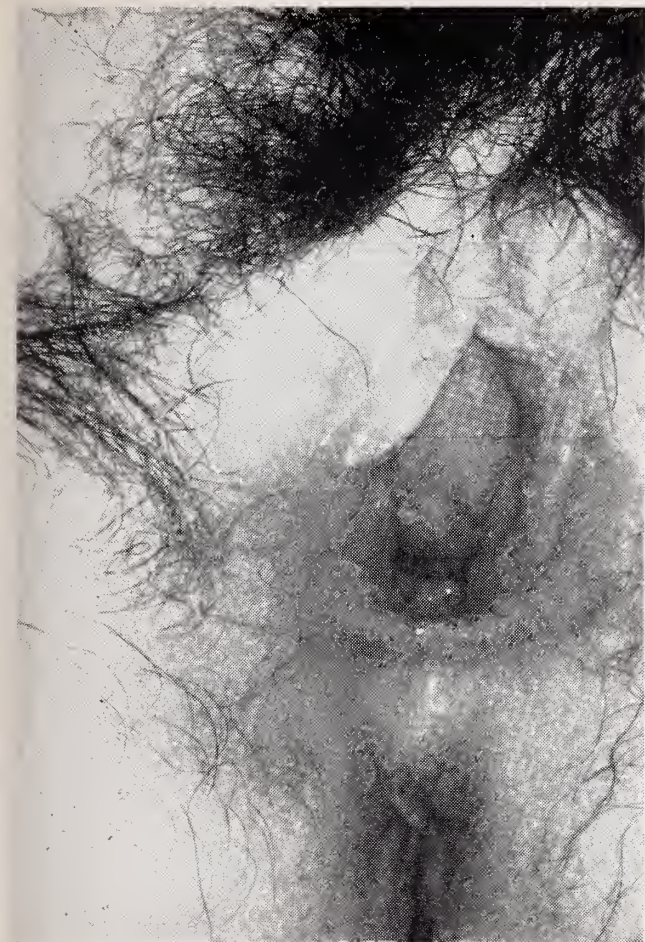


Fig. 2. The extension of the disease precluded the preservation of the perineum in this patient (D.L.).

can expect a considerable prolongation of the healing period and often with a varying degree of infection. (Figs. 2, 3, 4 and 5) One of the four cases developed small bowel obstruction several days after the operation and exploration revealed that a loop of small bowel had become compressed between the sacral promontory and the mesentery of several loops of small bowel which had fallen into the pelvis. After the obstruction was relieved, the convalescence was uneventful.

Discussion

This series is quite small and the selection which has been exercised has been great. The results that we are reporting are certainly not what one could expect from general application of the procedure. Brunschwig is now able to report approximately 25 per cent five-year cures in a series of cases where very little selection of patients was carried out. (Table III) In general it would seem that the results of the other authors as reported compare well with those of Brunschwig.

The mortality rate has been reduced from an initial level of 30 per cent to about 10 per cent. In a series as small as this the significance of there being no operative mortality lies, of course, not in the number of operations which has been carried out but in the fact that a procedure of this magnitude has been carried out only occasionally.

CURABILITY: CA. OF CERVIX (Brunschwig, Memorial Hospital)			
STAGE	INST. X	RAD. HAM.	MEM. HOSP.
I	55	70	82
II	55.8	52	58
III	14	24	32
IV	0	0	25
TOTAL	47.6	40	51
% 5-yr. cures			

TABLE III

These figures were given by Dr. Brunschwig to the James Ewing Society, March 7, 1953.

There has been considerable improvement in the management of the colostomy and the control of the urine. Some patients manage a so-called wet colostomy very well but to others it is an ordeal. Probably patients are better off with a dry colostomy and with the ureters in an isolated segment of bowel or opening on to the skin.

Our experience with this procedure has led us to feel that in general the requirements to be met before the operation is carried out are:

1. Limitation of the disease to the pelvis.

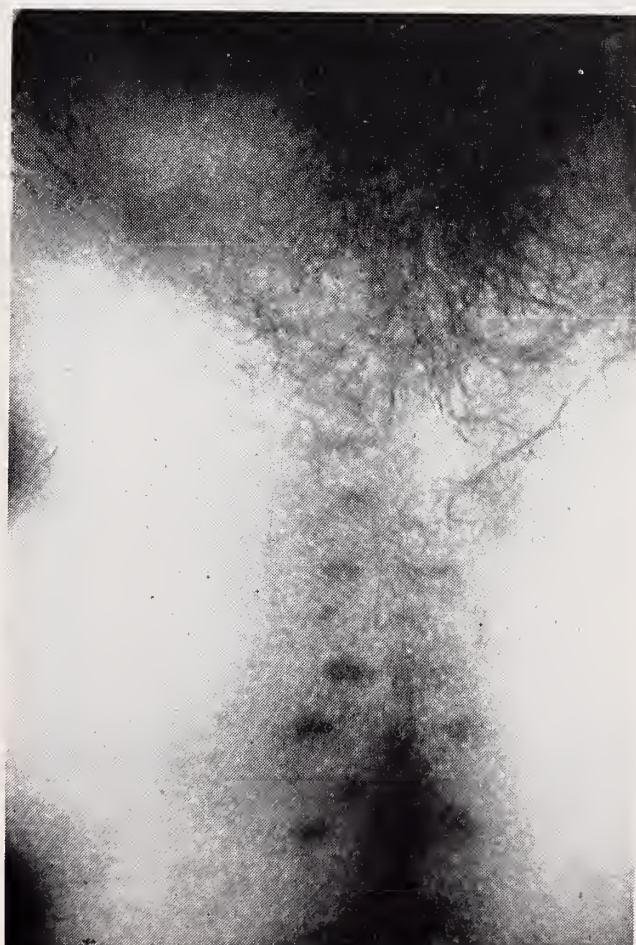


Fig. 3. The healed perineum of the patient shown in Fig. 2.

2. Advancement of the disease beyond the state of possible successful attack by irradiation or limited surgery.

3. A general physical condition adequate to tolerate the contemplated surgery.

4. Adequate hospital facilities and a medical and surgical team.

5. An understanding and cooperative patient and family.

6. An intense will to live on the part of the patient.

We are convinced that the latter requirement is absolutely essential. The burden which the surgeon takes upon himself in entering upon this procedure is great enough without there being added the onus of an unenthusiastic patient, worrying and complaining about the inconveniences of a colostomy.

In general we feel that among the contraindications are: (1) Extension of the disease beyond the pelvis and (2) definite fixation of the disease to the wall of the pelvis. It has been our experience that one can not determine absolutely the degree of fixation in some instances without exploration. Pain in the hip often does indicate infiltration of the lateral wall of the pelvis but it is not an absolute contraindication for there are not uncommonly instances of pain in the hip from some other coincidental cause.



Fig. 4. The patient (D.L.) was doing all of her housework one month after her operation.

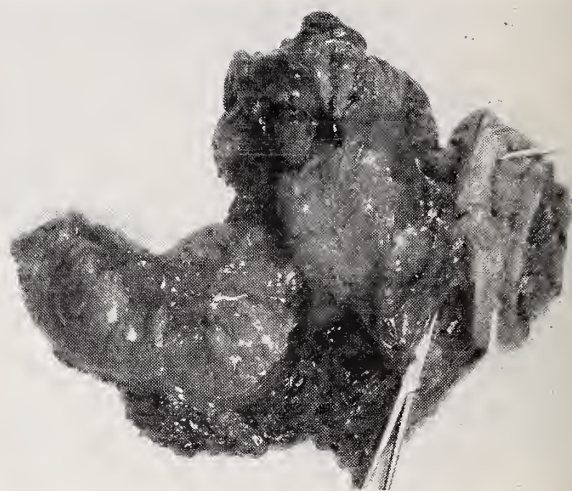


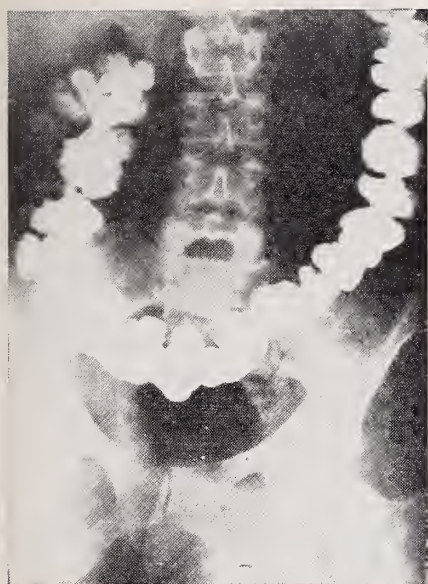
Fig. 5. The specimen included perineum, bladder, vagina, uterus, tubes, ovaries, and rectum. The probe passes through the urethra into the bladder and the arrow indicates the rectum.

There are still numerous unsettled points concerning the applications of this procedure. While we have not used it on patients over 60 it is conceivable that in well-preserved individuals, it might justifiably be applied in the older age group. It is our feeling that at present this procedure has its greatest applicability in lesions of the cervix and rectum but may be applied to some advanced lesions of the corpus of the uterus. More experience must be gained concerning the histological types of lesions and their clinical manifestations to determine which are to be attacked. This procedure is not likely to be applicable usually in cancer of the ovary and the prostate. In this particular study we have not applied the procedure to carcinoma of the bladder but have been interested in the work of other investigators, who have not been enthusiastic over their results. The procedure may have application in certain or occasional cases of cancer of the bladder. We do feel that radionecrosis even in the absence of residual cancer may be an acceptable indication for the operation. We also conceive that in some instances the procedure might be carried out for palliation alone, instances where there is extreme pain and where one might judge the course of the disease to be prolonged.

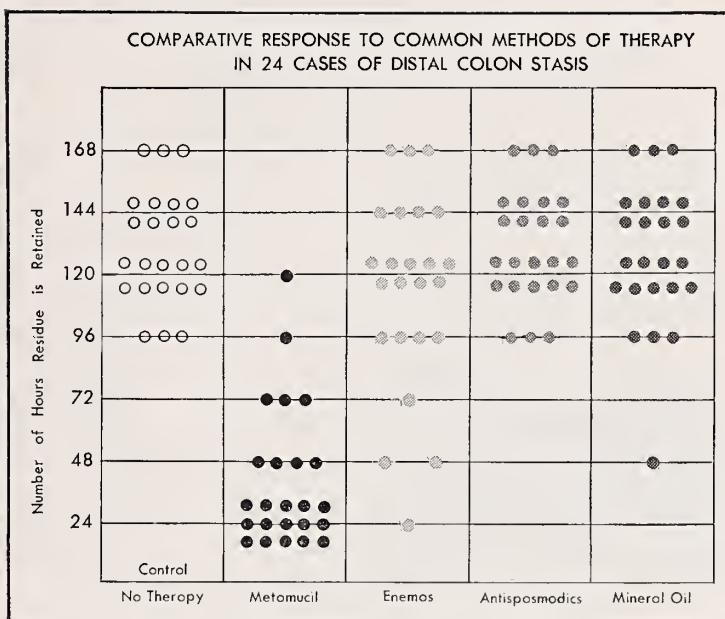
The ultimate cure rate produced by this procedure is yet to be determined but it seems from the available statistics that it will be at least 25 per cent for five-years and even higher in a highly selected group.

Additional experience in regard to the management of the ureters will be gained and we believe that this problem can be overcome in large part.

Both from our experience and from that of others, we feel that limitation of the procedure, for example the attempt to preserve either the rectum or bladder, is rarely justified and usually will greatly compromise the chance of cure. Because of the mode of spread of cancer from the cervix and the extremely close association of the various pelvic viscera, at-



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tempts to preserve one viscus in whole or in part in the face of advanced cancer usually will lead to failure to cure. Some investigators have reported that in no case in which the rectum was saved because the lesion appeared to be an anterior one was cure effected, while others do report success. We feel that it is probably more often justified to attempt to preserve the bladder when the lesion is on the posterior aspect of the cervix than it is to attempt to save the rectum when the lesion is anterior. It should be borne in mind that this operation represents in all probability the patient's last chance of cure and that chance should not be compromised. Having eliminated the contraindications and established the indications for the operation, the operator should proceed with the evisceration, attempting to encompass the diseased area as widely and cleanly as possible. At this point exploratory dissection of the pelvic viscera need not and should not be attempted; it only increases the chance of opening up planes containing disease.

While we have constructed wet colostomies in the patients reported in this study, we feel that probably it is better to have a separate dry colostomy and the ureters in an isolated segment of bowel. We have not constructed the ileocecal pouch more because of the added time than for any other reason. The technique of simply bringing out a loop of sigmoid or descending colon over a glass rod has considerable appeal because of its simplicity and economy of time.

Conclusions

We feel that the following conclusions are justified:

1. Pelvic evisceration can be carried out with a reasonable morbidity and a mortality of approximately 10 per cent.
2. Patients having had this operation can be comfortable, happy, and useful.
3. A certain percentage, as yet undermined but probably at least 25 per cent of patients subjected to this procedure, can be cured for five years.
4. The procedure may be justified for palliation in occasional instances.
5. A very careful selection of patients should be exercised.
6. The patient should have a strong will and enthusiasm to live.
7. Partial pelvic evisceration should be extremely limited in application.
8. Continued clinical application of the procedure for investigation and for practical purposes is warranted.
9. Application of the procedure generally is not yet to be advised.

Emory University Hospital

Discussion

G. P. McINNES, Augusta: The subject is a controversial one; to be decided in the experience of the individual surgeon. We have undertaken a similar study at the Medical College of Georgia without the

selection exercised by Dr. Wilkins, to include patients of practically all age groups, with disease localized in the pelvis. Older aged groups, especially those who are long time radiation survivors with subsequent failure, often present the most localized type of disease.

It would seem that aside from more or less definite physical requirements, the most important single prerequisite to radical pelvic surgery is the desire of the patient to run any risk for a chance at recovery. Often pain helps force the decision, but it is not a good idea to attempt to sell the operation. In addition the referring physician or family physician is often a keystone in the decision of the patient; a positive decision from him also helps to carry the patient over many of the rough spots. The team needed to help the patient reach a sound decision should include intelligent patients who have responded to surgical therapy, have a reasonable chance to survive and who have first hand insight into many of the problems of colostomy and ureterostomy, etc. Several of our younger patients, are able to talk freely before other patients, students and physicians, and even lay audiences.

The work of Sutherland of the Memorial Center, New York City, in the study of the psychological aspects of radical surgery will give us a less prejudiced view than that of the surgeon. However, it still remains a fact that few patients refuse surgery themselves, mutilating as it may be, but rather are refused operation and classified as inoperable by the surgeon.

Another problem that has constantly been with us, as mentioned by Dr. Wilkins, is the management of the complications relating to the urinary tract. Often a dilated, chronically infected, poor functioning urinary tract presents almost insurmountable tests of the ingenuity of the surgeon. Fortunately an apparently poor functioning kidney may be sufficient to preserve life. Several patients with only one kidney in poor condition according to the usual function tests, maintain reasonable activity after release of obstruction and transplantation of the ureter at operation. We have found that the most constant use of gantricin or Elkosin helpful in these patients.

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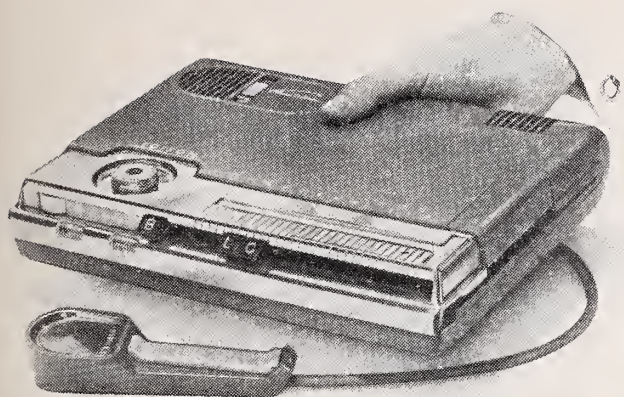
In Georgia, great progress has been made in the prevention of cases, and of deaths in childhood, from such communicable diseases as diphtheria, whooping cough, typhoid, and from motor vehicle accidents. Consequently accidental deaths and injuries from causes other than motor vehicles are assuming greater importance in the thinking of persons and groups concerned with the health and welfare of children. Most recent statistics from the Georgia Department of Public Health show that accidents, other than those from motor vehicles, are the leading cause of death in children aged one through fourteen years.

In 1952, the lethal non-motor vehicle accidents to Georgia children under fifteen, were due to six major causes. Listed in order of numerical importance for the entire age group, from one through fourteen

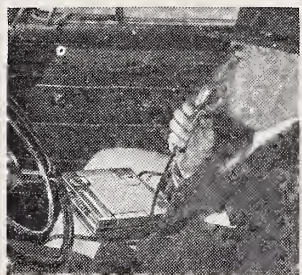
years, they were: 1. Accidental suffocation in bed and inhalation and ingestion of food causing obstruction or suffocation. 2. Burns. 3. Drowning and submersion. 4. Poisoning. 5. Falls. 6. Firearms and explosives. Also, it has been roughly estimated that for each fatal accident which occurred there were 30 or 40 childhood accidents which required medical aid.

If a doctor has happened to see a child for a minor or major accident, he should have had the opportunity to look over the home surroundings and give anticipatory guidance against further accidents. Physicians, parents, public health personnel, and the community could well cooperate to learn about and provide protection against the hazards peculiar to their locality, while at the same time they provided education for the children to help them develop caution and self assurance.

Too, the physician can recognize the traits which indicate that a child and/or his family are accident prone. By counseling with the parents at an early stage, he may enable them to recognize and give attention to the factors which are causing the trouble.



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Parents may be able to modify the attitudes and/or environment, or at least be on the alert to help the child avoid situations which could be hazardous. Physician safety teaching by listening, looking, reasoning, and discussion must necessarily take place in advance of the child's growth into the hazards of an expanding environment.

Each step in age brings an increasing range of interests and new hazards. On the basis of known patterns of activities and interests by age group, and of the Georgia accident pattern, certain remedies are immediately apparent.

An infant's relative helplessness is obvious, but some parents must still be taught that the simple act of leaving the baby alone with his bottle propped against a pillow can cause a fatal accident, and that too heavy bed clothes or too constricting bed wear can be hazardous.

From one to three years of age, the physician should guide the parents to recognize the child's growing curiosity and the necessity for providing absolute protection from fire, i.e., house heating devices—gas or oil heaters, wood or coal burning fireplaces, stoves used for cooking, grass or bonfires, and explosion of combustible materials, such as gasoline and firecrackers; contact with hot substances, corrosive liquids and steam; water hazards; ingestion of medications and of such utilitarian things as lye and kerosene; from inhalation and ingestion of food causing obstruction or suffocation; and from unprotected stairways, porches and steps. Small children do not recognize water hazards, even such a usual situation as the bath tub, or the duck pond.

The growing boy's interest in matches, open fires, electrical equipment and fireworks, suggests easily applicable protective and educational measures designed to reduce the ghastly toll from burns, one of the greatest sources of permanent physical, emotional and financial damage in the entire accident field. Increasing interest in firearms implies the great need for education in their proper use, and in safe ways of handling, to avoid tragedy and heartbreak. The lure of field and stream, as the boy grows older, suggests the need of protection, but chiefly the need of education in water safety, particularly in areas where "water holes" are numerous, often obscure, and relatively unfrequented, and where beaches are accessible, though unfrequented and unprotected.

All too often the physician is tempted to teach safety on the fear basis. However, it is more and more being recognized that children whose safety education has been started early by their physicians through their parents, with due respect for growth and development patterns, and for environmental hazards, grow into increasing responsibility with their years. Such children also unconsciously learn to distinguish between the impulsive immediate satisfactions which are the mark of the accident prone and the less direct but more adequate satisfaction of

"safe ways of doing things." Self-assured in the capabilities they themselves with guidance have developed, children can become happy, relatively safe and self-confident individuals.

And safety habits developed in children in their formative years are most likely to become life long safety habits.

IMPORTANT CAUSES OF DEATH IN ORDER OF RANK IN 1 THROUGH 14 YEAR AGE GROUP, IN GEORGIA, 1952
(Resident Data)

Total, All Causes	1,035
1. Accidents exclusive of motor vehicle accidents (E800-E802, E820-E962)	192
(a) Burns (E916-E917)	60
(b) Drowning and submersion (E929, E850)	40
(c) Poisoning by liquid and solid substances (E870-E888)	21
(d) Accidents caused from firearms and explosives (E919)	20
2. Pneumonia and Influenza (480-483, 490-493)	133
3. Motor vehicle accidents (E810-E835)	104
4. Malignant neoplasms (140-205)	68
5. Congenital malformations (750-759)	51

Source: Georgia Department of Public Health
Central Statistical Unit
October 19, 1953

IMPORTANT CAUSES OF DEATH IN ORDER OF RANK IN UNDER 15 YEARS AGE GROUP, GEORGIA, 1952
(Resident Data)

Total, All Causes	4,193
1. Immaturity unqualified (774-776)	645
2. Influenza and pneumonia (480-483, 490-493, 763)	591
3. Postnatal asphyxia and atelectasis (762)	372
4. Congenital malformations (750-759)	365
5. Accidents exclusive of motor vehicle accidents (E800-E802, E840-E962)	330
(a) Suffocation in bed and inhalation and ingestion of food causing obstruction or suffocation (E921, E924)	103
(b) Burns (E916-E917)	68
(c) Drowning and submersion (E850, E929)	43
(d) Poisoning (E870-E888)	22
(e) Falls (E900-E904)	20
(f) Firearms and explosives (E919)	20

Source: Georgia Department of Public Health
Central Statistical Unit
October 19, 1953

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The Children's Hospital—Available from the Children's Medical Center, 300 Longwood Avenue, Boston 15, Massachusetts.
2. *American Journal Public Health*—Vol. 42, No. 7—July, 1952. *Mortality Statistics as a Direction Finder in Home Accident Prevention* I. Jay Brightman, M.D., M.S.P.H., Isabel McCaffrey, and Leonard P. Cook, p. 840. *Clinical Application of the Theory of Accident Prevention in Childhood*. Harry F. Dietrich, M.D. p. 849.
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doctor placement page

Available Locations

Apalachicola, Florida—Small, well operated county hospital. New modern doctors building for rent, which is well equipped. Doctor-surgeon desired. Contact: G. Cecil Gibbs, Chamber of Commerce, Apalachicola, Florida.

Arlington, Georgia—(Calhoun County) In need of surgeon for practice in the new Terrell County Hospital (28 beds). Contact: Mr. W. B. Bostwick, Arlington City Hospital, Arlington, Georgia. (pop. 1,382)

Austell, Georgia—(Cobb County) Excellently equipped 16 bed hospital with first rate facilities in nearby Marietta and Atlanta. Contact: Dr. J. G. Bussey, Austell Hospital, Austell, Georgia. (pop. 1,230)

Bainbridge, Georgia—(Decatur County) Office furnished and available now. Need general practitioner. Contact: Dr. Henry A. Bridges, 402 S. West Street, Bainbridge, Georgia. (pop. 7,562)

Broxton, Georgia—(Coffee County) Doctors clinic available, also home. 60 room county hospital at Douglas. 7 room doctors building. Contact: Mr. L. L. Denton, Sr., P. O. Box 198, Broxton, Georgia. (pop. 890)

Cairo, Georgia—(Grady County) Grady County Hospital at Cairo, 31 beds. Suitable office facilities with exam room, etc., available reasonably. Houses available for purchase or rent. Needs two physicians. Contact: Mr. Louis A. Powell, P. O. Drawer 387, Cairo, Georgia. (pop. 9,500)

Clarkston, Georgia—(DeKalb County) Needs general practitioner. Offices available rent free. Contact: Mrs. M. E. Flowers, Clarkston, Georgia. (pop. 1,165)

Conyers, Georgia—(Rockdale County) Hospital clinic now in process of being built between Conyers and Millstead. Office space can be rented reasonably. Houses can be rented or bought. Contact Mr. O. J. Bradford, Conyers, Georgia. (pop. 2,004)

Crawford, Georgia—(Oglethorpe County) Two hospitals in Athens. Office space available for rent. Housing can be arranged satisfactorily. Contact: Mr. C. A. Townes, Crawford, Georgia. (pop. 10,000)

Douglas, Georgia—(Coffee County) New Hill-Burton hospital (65 beds) Office space available for rent. Housing can be arranged. Need pediatrician, surgeon, diagnostician. Contact: Dr. T. H. Clark, Douglas, Georgia. (pop. 10,000)

Hampton, Georgia—(Henry County) Hospital in Griffin. Office space, housing available. Contact: Mr. A. L. Cain, Cain's Pharmacy, Hampton, Georgia. (pop. 1,000)

Hawkinsville, Georgia—(Pulaski County) Has a 40-bed hospital. Two suites being built for doctors office. Contact: Mr. W. N. Pate, Chairman, Taylor Memorial Hospital, Hawkinsville, Georgia. (pop. 3,342)

Homerville, Georgia—(Clinch County) Offices available without charge. Private hospital. Contact: Mr. E. K. Avriett, Homerville, Georgia. (pop. 1,787)

Lakeland, Georgia—(Lanier County) One hospital in County. Plenty of office space. Housing is available. Doctors to take over operation of new hospital. Contact: Mr. J. B. Powell, Lakeland, Georgia. (pop. 1,502)

Leesburg, Georgia—(Lee County) Office space available, free. Houses for rent reasonable. Home large enough for office. No physician in county. Contact: W. F. Faircloth, Ph.G., Leesburg, Georgia.

Logansville, Georgia—(Walton County) Legion completing a doctors building. Six room houses available. Contact: Dr. Chas. S. Floyd, Loganville, Georgia. (pop. 700)

Lumber City, Georgia—(Telfair County) Nice brick office building. New hospital in same county. Five room and bath office, rent free for two years. Contact: Mr. T. D. Wooten, Wooten Drug Company, Lumber City, Georgia. (pop. 2,500)

Meigs, Georgia—(Thomas County) Available clinic with all facilities. (pop. 927) Contact: Dr. J. N. Isler, Meigs, Georgia.

Midville, Georgia—(Burke County) Has an 8 room clinic. Nice 3 bedroom home. Clear from \$15,000 to \$20,000 annually. Contact: Mr. J. Rife English, Midville, Georgia. (pop. 682)

Newnan, Georgia—(Coweta County) Excellent opportunity for Negro physician. All hospital facilities and privileges granted by white doctors. Modern housing, good schools, churches. Contact: Dr. G. P. Kinnard, Newnan, Georgia. (pop. 8,218)

Newton, Georgia—(Baker County) Hospital in Camilla, 9 miles away. Can rent or purchase an office. Apartments for rent. Contact: Mr. R. F. Mulford, Newton, Georgia. (pop. 503)

Pearson, Georgia—(Atkinson County) Will furnish house, and equip clinic. New Hill-Burton hospital at Douglas (15 miles) guarantees staff privileges to GP. Office will be rent free for six months. Contact: Mr. Barney Kraft, Pearson, Georgia. (pop. 1,402)

Smithville, Georgia—(Lee County) Home in Leesburg, office downtown. Completely equipped office of 2 rooms and connecting lavatory and toilet with outlets for sterilizers, etc. attached. All private practice available. Contact: Mr. Chas. A. Dean, Smithville Drug Store, Smithville, Georgia. (pop. 700)

Snellville, Georgia—(DeKalb County) Office and home under construction, rent free. Community will support doctor. Contact: Mr. Ralph Head, Snellville, Georgia. (pop. 500)

Temple, Georgia—(Carroll County) Office space available. Either rent or purchase home. Two hospitals easily

accessible from Temple. Contact: Mr. L. G. Lyell, Temple, Georgia. (pop. 900)

Tifton, Georgia—(Tift County) Local hospital available. Housing available at reasonable cost. Need GP and EENT. Contact: Mrs. Agnew Andrews, Tifton, Georgia. (pop. 15,000)

Thomson, Georgia—(McDuffie County) Office space in modern building, steam heat, air conditioned. Can supply office furniture if necessary, carpets for floors, etc. Can also supply janitor service. Contact: Mr. G. C. Fite, Knox Building, Thomson, Ga. (pop. 3,100)

Unadilla, Georgia—(Dooly County) Hospital in county. Office space available or will build small clinic and let doctor rent or buy. Housing will be provided, rent or buy. Guaranteed a good doctor will do well. Contact: Mr. E. H. Conner, Unadilla, Georgia. (pop. 1,200)

Warner Robins Air Force Base, Georgia—(Bibb County) Vacancy for a medical officer (occupational medicine) GS-12, \$7040 per annum. Also for medical officer (general supervisory) GA-13, \$8360 per annum. Contact: Karl McPherson, Chief, Civilian Personnel Division, Warner Robins Air Force Base, Warner Robins, Georgia.

Warthen, Georgia—(Washington County) Office space available for rent. Full time physician would have more work than he could do. Contact: Mrs. Macon Warthen, Warthen, Georgia. (pop. 200)

Watkinsville, Georgia—(Oconee County) \$5,000 loan available to doctor interested free to construct office, rent free. Contact: Mr. Frank E. Stancil, Watkinsville, Georgia. (pop. 800)

Whigham, Georgia—(Grady County) New clinic. Housing available, buy or rent. \$2,000 raised for physician to locate in Whigham. Contact: Mr. N. Z. Trulock, Whigham, Georgia. (pop. 700)

Winder, Georgia—(Barrow County) 40-bed hospital recently opened. Office space available for rent. Adequate housing available. Need GP's, surgeon. Contact: Mr. W. C. Harris, Winder, Ga. (pop. 4,604)

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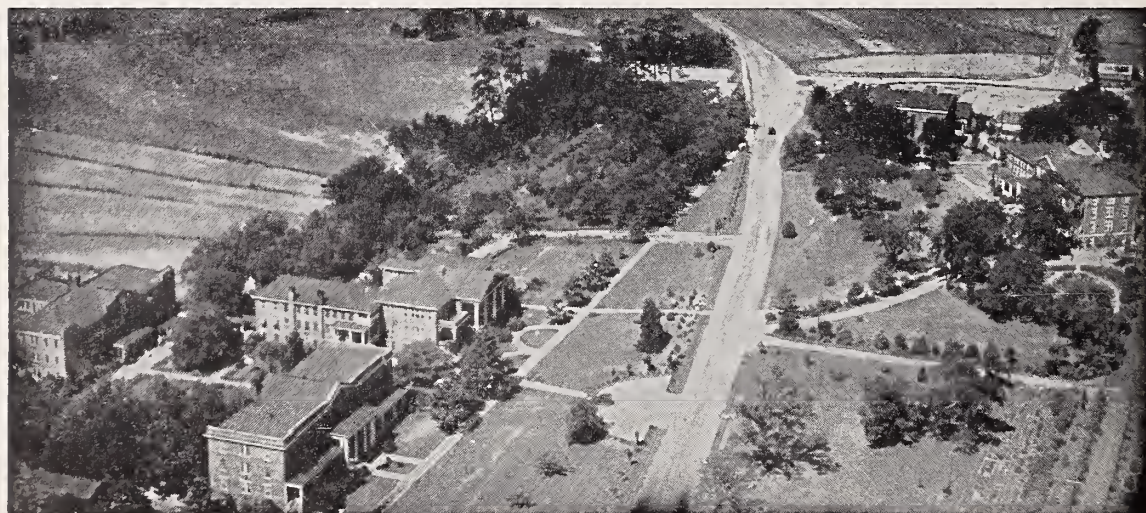
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abstracts by georgia authors

Bossak, Hilfred N.; Tarris, Ad; Duncan, Wm. P.; Olansky, Sidney and Chester, Benjamin J., Ven. Dis. Research Lab. US Public Health Service, Chamblee, Ga. "Mazzini Cardiolipin Microflocculation Test in The Serology of Syphilis." *Am. J. of Syph., Gonorr. & Venereal Disease* 37:536-539 (Nov.) 1953.

This paper presents the comparative results obtained with the Mazzini Cardiolipin Microflocculation test and a battery of nine (9) serologic tests employing both lipoidal and cardiolipin-lecithin antigen on a selected group of patients. When test results were correlated with clinical findings, it was found that the Mazzini Cardiolipin Microflocculation test was the most reactive technique when employed on specimens from a syphilitic infection. The group of tests employing lipoidal antigen (Mazzini lipoidal, Eagle Flocculation and Kahn group of patients with clinical or anamnestic evidence of Standard tests) produced a greater number of reactions in the nonsyphilitic patient category than did the technique employing cardiolipin-lecithin antigen with the exception of the Mazzini Cardiolipin Microflocculation test. In addition, the latter test produced the greater number of reactions in the presence of completely negative findings with the other eight (8) tests.

Cowart, G. T. and Fort, C. A., Emory University School of Medicine, Emory University. "Intestinal Obstruction as a Complication of Ureterosigmoidostomy." *Am. Surg.* 19:1167-1170 (Dec.) 1953.

Uretero-intestinal anastomosis is beset with many complications peculiar to this type of surgery, as well as by the usual possible problems following any major surgical procedure. The former type of complications have been artificially divided into primarily biochemic, urologic and intestinal categories. Biochemic changes include hyperchloremic acidosis and hypopotassemia. Urologic problems include ureteral reflux, ureteral meatal stenosis, ureteritis, ureterectasis, hydronephrosis, calculi, cortical abscesses, pyelonephritis and urinary fistulae.

The third group of special complications of ureterosigmoidostomy, the intestinal type, is stressed in this paper because of the relative lack of emphasis on this problem in the literature. These complications include paralytic ileus, chronic diarrhea, fecal fistulae and especially intestinal obstruction. Two cases of intestinal obstruction, one of volvulus and one of intussusception, are reported in detail for emphasis. Apparently intestinal obstruction occurs in about one per cent of cases of uretero-intestinal anastomosis. Since paralytic ileus or peritonitis with resultant abdominal distention occurs in

about 12.2 per cent of cases and since these common complications can be mistakenly diagnosed when intestinal obstruction is present, this latter possibility should always be kept in mind. It is, of course, frequently life-saving to make this accurate early diagnosis.

Foraker, Alvan G., and Denham, Sam Wesley, Emory University School of Medicine. "Histochemical Localization of Succinic Dehydrogenase and Endogenous Reductase Activity in Squamous Cell Carcinoma of the Cervix." *Texas Rep. Biol. & Med.* 11:643-652, Winter, 1953.

Sites of succinic dehydrogenase and endogenous reductase activity were studied in invasive squamous cell carcinoma, intraepithelial carcinoma, metaplastic and normal portio vaginalis squamous epithelium of the cervix by incubating tissue block in neotetrazolium. These enzymes play vital roles in respiratory processes of most living cells and are concerned with the oxidation of lipids, carbohydrates and proteins. Their distribution has been found to correlate with cell metabolism in various human, animal and plant tissues. In the present study, in general manifestation of dehydrogenase activity occurred in the basal layer of normally maturing squamous epithelium but more diffusely through the other types of epithelium. This distribution, both of specific succinic dehydrogenase and of general endogenous reductase activity corresponds to sites of cell proliferation. (From the Departments of Pathology and Obstetrics and Gynecology, Emory University School of Medicine and Grady Memorial Hospital, Atlanta, Georgia).

Goldman, Morris, CDC Center, Laboratory Branch, Box 185, Chamblee. "Cytochemical Differentiation of Endamoeba Histolytica and Endamoeba Coli by Means of Fluorescent Antibody." *Am. J. Hyg.* 58:319-328 (Nov.) 1953.

1. Antiserum to *Endamoeba histolytica* was prepared in rabbits by subcutaneous inoculations of intact, washed amebae. The globulin fraction of this antiserum was separated and conjugated to fluorescein.

2. Methanol-fixed *E. histolytica* organisms, when exposed to conjugated antiserum, became fluorescent. Suitable controls are described which establish this result as due to a specific immunochemical reaction.

3. The cross-reaction which occurred between anti-*E. histolytica* conjugate and *E. coli* organisms was absorbed with large numbers of intact *E. coli* organisms. Absorbed conjugate did not stain *E. coli* but continued to stain *E. histolytica* with almost undiminished intensity.

Haines, Thomas W., CDC, Public Health Service, Thomasville, Georgia. "Breeding Media of Common Flies. I. In Urban Areas." *Am. J. Trop. Med. & Hyg.* 2:933-940 (Sept.) 1953.

A year's study (1950-51) on the production sources and seasonal abundance of the more common muscoid flies, conducted in two urban communities in southwest Georgia and characterized by moderate winter temperatures and high annual rainfall, showed that *Musca domestica* was produced by a wide range of breeding media throughout the entire period, far exceeding all other fly species. This wide adaptability, plus the house fly's enormous reproduction potential, probably accounts for its demonstrated ability to develop insecticide-resistant populations rapidly. The occasional high production of other common species from any one of five principal fly breeding media categories was offset by its relatively infrequent occurrence or its restriction to certain items of breeding material. Animal refuse (excrements, pen litter and wastes) occurred most frequently of all categories of media examined and were the most fly productive breeding materials. Species composition of flies counted indoors during the period of the study showed the 99 per cent were house flies. This species preference for human association, coupled with its abundance coincidental with diarrheal disease in the study area, further establishes it as the major species to be considered in this area. Certain other species such as *Phaenicia* spp., *Callitroga macellaria* and *Sarcophaga* spp., comprised less than one per cent of flies in houses.

Harland, W. A., Emory University School of Medicine, Emory University, "Granular-Cell Myoblastoma of the Hypophyseal Stalk." *Cancer* 6:1134-1138 (Nov.) 1953.

A large primary tumor with all the characteristics of the so-called granular-cell myoblastoma was found in the region of the floor of the third ventricle in a negress who died with the signs and symptoms of increased intracranial pressure. The tumor which was histologically benign, appeared to have arisen in the hypophyseal stalk. Much smaller, but histologically similar, lesions were described thirty years ago, and these small lesions are probably not too unusual, as careful examination of the hypophysis at autopsy disclosed two such lesions in a short period of time.

Howard, Albert R., Hamilton, W. F. and Dow, Philip, Dept. of Phys. Medical College of Georgia, Augusta. "Limitations of the Continuous Infusion Method for Measuring Cardiac Output by Dye Dilution." *Am. J. of Phys.* 175:173-177 (Nov.) 1953.

The validity of determining cardiac output from the plateau reached by a continuous infusion of foreign substance has previously been questioned. Simultaneous injection of the two dyes, Brilliant Vital Red and Evans Blue were made; one as a "slug" and the other continuously. Spectrophotometric analysis allowed determination of the two dyes individually in the same samples. This gave two separate curves, one as a peak, the other as a continuous rise, from which cardiac output determinations were attempted.

In perfusions of models on organs without recirculation, continuous infusion of Brilliant Vital Red and simultaneously started quick injection of T-1824 gave concordant results. In intact animals, continuous infusion yielded useful curves only in the infrequent cases when recirculation did not interrupt the first passage of the quick injection. Spurious plateaus can result from respiratory fluctuations in flow. Perfusion of the lungs alone gives atypical quick-injection curves with non-linear semilog disappearance.

King, James T., 384 Peachtree St., Atlanta. "The Condition of Fluid in the Middle Ear. Factors Influencing the Prognosis in 56 Children." *Annals of Otolaryngology, Rhinology and Laryngology.* 62:496-506 (June) 1953.

This condition (also known as serous or secretory otitis media) is now the most common middle ear trouble in childhood. The middle ear fills with thin or thick fluid and the chief symptom is hearing loss. The physical findings are somewhat obscure and it is frequently overlooked. It is usually associated with nasal allergy and or obstructing adenoids.

In 56 cases, the T and A operation was done and at the same sitting the ears were opened and the fluid was evacuated. The fluid was examined and the findings were correlated with the subsequent course of the case. From this the writer was able to establish or verify the following:

1. Some cases get well with little or no treatment, whereas others run a prolonged or relapsing course despite all efforts at a cure. 2. In cases where the fluid is thick, the eustachian

tube becomes blocked with a "Mucous plug." These cases constitute a more difficult problem.

3. If the smears taken from this "plug" contain eosinophils the prognosis as regards resolution is even worse. Whereas, if bacteria were found the prognosis was somewhat better. 4. The presence of bacteria was considered evidence of a secondary bacterial infection of the fluid itself rather than an ordinary suppurative otitis media.

5. In two cases both bacteria and eosinophils were found in the same smear. 6. Nonsurgical mastoiditis is frequent complication. 7. Practitioners of the 19th century understood this condition about as well as those of the 20th. In fact the finest treatise ever written on the subject was dated 1869 (Politzer).

Logue, R. Bruce and Hurst, J. Willis, Dept. of Medicine, Emory University School of Medicine. "Congestive Heart Failure in Children." *GP* 8:41-54 (Dec.) 1954.

Signs and symptoms of congestive heart failure in children are often misinterpreted and the etiology may appear obscure. In a small child, a rapid respiratory rate, hepatomegaly with few pulmonary rales are the common features of early congestive heart failure. The great majority of cases of congestive heart failure in children are due to rheumatic myocarditis. Patent ductus arteriosus, coarctation of the aorta, high ventricular defect, and interatrial septal defect are the common congenital defects unassociated with cyanosis, which cause heart failure. Complete transposition of the great vessels is the commonest lesion associated with cyanosis causing heart failure in early life. Tetralogy of Fallot, on the other hand, rarely produces heart failure. Endocardial fibrosis produces heart failure and death in the first two years of life. Heart failure may complicate paroxysmal tachycardia in early life and prompt therapy may be lifesaving. Acute glomerulonephritis is commonly accompanied by congestive heart failure. Digitalis mercurial diuretics, oxygen, and aminophylline are useful in treating heart failure in children. Emphasis should be placed on the prompt treatment of respiratory infection in the child with cardiac disease. Heart failure is an urgent indication for operative repair of correctable lesions.

Mickle, Walter A. and Ades, Harlow W., Dept. of Anatomy, Emory University School of Medicine. "Spread of Evoked Cortical Potentials." *J. of Neurophys.* 16:608-633 (Nov.) 1953.

Studies made on the characteristics of the electrical potentials which are evoked in the auditory cortex of the cat by click stimulation have demonstrated the presence of "waves" which travel across the surface of the cortex. Using oscillographic techniques, it has been shown that there are two cortical areas activated by the sound. For a period of about 5 milliseconds (msec.) following the click, no evoked activity is demonstrable in the cortex. By 6 msec. after the sound, a field of positive potential appears in the anterior suprasylvian gyrus, outside the usual auditory area. This field persists for 20-30 msec. and dies away without appreciable spread. About 9 msec. after the click, the primary auditory area shows a negative potential over its entire surface. A short time (2-3 msec.) later, a spot of positive potential appears in the middle of the previously negative area, and then spreads in an irregularly radial pattern, to die away near the borders of the auditory area, some 7-9 msec. later.

Experiments involving the removal of the "focus" or origin of the positive waves and their interruption by shallow knife cuts in the cortex suggest that the auditory signals are delivered diffusely to the entire auditory cortex, following which a transcortical wave appears in a small spot and spreads through the superficial layers of the cortex to most of the auditory area.

Webb, Clarence F. and Harder, Joseph A., Dept. of Ob. & Gyn., Station Hospital, Robins Airforce Base, Ga. "Kyphoscoliosis and Pregnancy." *Obstetrics & Gynec.* 2:654-657 (Dec.) 1953.

A single case report of a 19-year-old, white, primigravida with marked kyphoscoliosis is presented. The literature is briefly reviewed and the cardio-respiratory problems stressed. The patient had a marked decrease of the respiratory reserve. The vital capacity was 1000 cc or about a third of the normal for her height and weight. During the eighth month of the pregnancy the patient developed a pneumonia and subsequently delivered a stillborn male infant. Pleural effusion, congestive heart failure, gastrointestinal bleeding and pre renal azotemia were secondary complications. The patient made a full recovery.

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1. Werner, A.: Acta endocrinol. 13:87, 1953.

2. Malleson, J.: Lancet 2:158 (July 25) 1953.

3. Goldzieher, M. A., and Goldzieher, J. W.: Endocrine Treatment in General Practice, New York, Springer Publishing Company, Inc., 1953, p. 23.



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REST IN HEART FAILURE

IN OUR ENTHUSIASM over new forms of digitalis, better diuretics and more careful salt restriction, doctors often forget that proper rest is still one of the fundamental treatments in congestive heart failure. In order to be effective the rest should be physical, emotional and metabolic.

1. Physical rest: Although complete bed rest is sometimes necessary in acute conditions such as myocardial infarction, it is widely recognized that even the patient in severe congestive heart failure can often rest better in a comfortable chair than in bed because of his orthopnea. Thromboembolic complications are so frequent in heart failure that certain minimal exercise is to be desired. Deep breathing and leg exercises are often encouraged.

After the acute failure is controlled, most cardiacs return to some degree of their former activity. Careful evaluation of the patient's ability to work should allow the doctor to advise him what types of activity he may undertake. Many times the patient can return to his former line of work with certain modifications. Again vocational rehabilitation and job placement experts will be called upon to help. Only rarely is the cardiac a complete invalid.

The job of the doctor is usually not to restrict the patient, but to guide his activities into channels which will be productive but not strenuous or tiring.

2. Emotional: It is easy to overlook the fact that emotions such as anger, fear, apprehension, worry or excitement can increase the cardiac output over 200 per cent. Increases of this magnitude in the work of the heart are poorly tolerated in a person already in heart failure. There is no short cut to the proper understanding of this fact by the patient. The doctor must sit down with him and explain the mechanism of these increases in work to him and work out with him methods by which he can avoid emotional stresses of all types. Hidden sources of stress must be searched for by the doctor and the patient and removed. It must be remembered that the emotions engendered by sexual intercourse produce a great increase in cardiac output, regardless of the degree of physical exertion involved.

The patient must particularly avoid working under pressure or at great speed, and his relationships with his fellow workmen and employer are of utmost importance. He is much better off making half the money in a job which he can successfully tolerate over many years, than in a job making a high salary which will make him deteriorate rapidly.

3. Metabolic rest: Since fat is a very vascular tissue, it follows that a patient who has large amounts of excess fat is placing a large additional burden on the heart. Every effort should be made to reduce the person in heart failure and to maintain his weight at about 10 pounds below his normal weight. This not only reduces his resting cardiac output, but during such usual activities as walking and stair climbing the thin man requires far less energy output than does the fat man.

Another metabolic factor to consider is the increased cardiac output demanded during digestion. The patient in failure should avoid heavy meals at all times.

Certain metabolic disorders such as hyperthyroidism can double or even triple the normal resting cardiac output. Every effort should be made to search for and remove the causes of these increased demands of the body for blood. This is particularly true in the patient who is in failure for which you can find no obvious cause.

Beri-beri, arteriovenous fistulae, moderate or severe anemia, fever and infection, chronic lung disease, and abnormal communications within the heart itself are other causes of increased demands on the heart which should be searched for and removed whenever possible.

In summary, the doctor who is treating heart failure should keep in mind that the basic cause of this failure is the inability of the heart to furnish enough blood to meet the demands of the body. When every treatment which may strengthen the heart and increase its ability to meet this demand has been exhausted then the only other treatment, other than symptomatic, is to reduce the demand on the heart. This can only be accomplished by proper rest—physical, emotional, and metabolic.

Notes on practical aspects of cardiovascular diseases . . .
a monthly contribution of the Georgia Heart Association.

Report of

PUBLIC HEALTH COMMITTEE

Meeting, Atlanta, January 7, 1954

ATTENDING A MEETING of the MAG Public Health Subcommittee at 4 p.m., Thursday, January 7, at the Academy of Medicine, Atlanta, were the following: T. A. Sappington, Thomaston, chairman; Evan W. Molyneaux, Hogansville; J. B. Neighbors, Athens; J. T. Holt, Baxley; J. M. Byne, Jr., Waynesboro; Sylvester Cain, Norcross; H. G. Lee, Millen; Ernest Thompson, Monroe; James R. Thomas, Griffin; J. Gregg Smith, Valdosta; O. H. Cheek, Dublin; C. J. Maloy, McRae; David M. Wolfe, Albany; H. L. Erwin, Dalton; F. O. Garrison, Demorest and S. C. Rutland, T. F. Sellers and Guy V. Rice, Atlanta.

The following action was taken:

1. *Recommended* that MAG Council approve plans for the Salk Polio Vaccine Field Trial in Georgia in February, 1954 to be administered by the

Public Health Department and the National Foundation for Infantile Paralysis.

2. *Recommended* that MAG Council endorse the present policy of Public Health Department relative to the allocation of state and federal funds to communities for the assistance in construction of hospital and public health centers.

3. *Recommended* that MAG Council consider appropriate action concerning Resolution No. 16, introduced at the recent A.M.A. Clinical Session in St. Louis in regard to the Manion Commission.

4. *Recommended* closer cooperation between the medical profession and public health officials.

5. *Received* a report from Dr. Sellers concerning the successful transference of operation of the Eugene Talmadge Memorial Hospital from the State Board of Health to the Board of Regents.

Report of

MAG COUNCIL MEETING

Meeting, Rome, January 17, 1954

THE FOURTH REGULAR (Winter) Meeting of MAG Council was held at 10 a.m., January 17, 1954, at the Hotel Greystone, Rome, Ga. Presiding was Harry L. Cheves, chairman. Present were William Harbin, president; Peter B. Wright, president-elect; David Henry Poer, secretary-treasurer; Mark Dougherty, assistant secretary-treasurer and Eustace Allen, Delegate. Councilors present were Lee Howard, First District; George R. Dillinger, Second District; W. G. Elliott, Third District; J. W. Chambers, Fourth District; Mark Dougherty, Fifth District; H. D. Allen, Sixth District; D. L. Wood,

Seventh District; Neal F. Yeomans, Eighth District; W. B. Schaefer, Ninth District and H. L. Cheves, Tenth District. Vice councilors present were Charles T. Brown, First District; C. S. Pittman, Second District; Clarence B. Palmer, Fourth District; J. G. McDaniel, Fifth District; R. W. Fowler, Seventh District and James M. Hicks, Eighth District.

An abstract of Council's actions follows:

1. *Approved* the MAG Budget for 1954 as presented by the Budget Committee.

2. *Approved* two recommendations presented by

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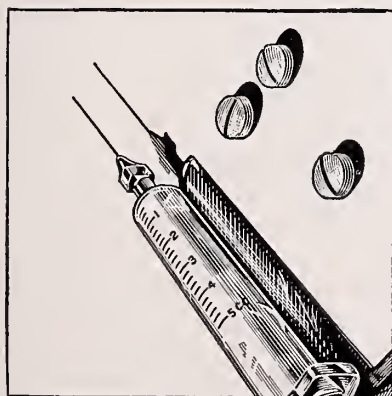
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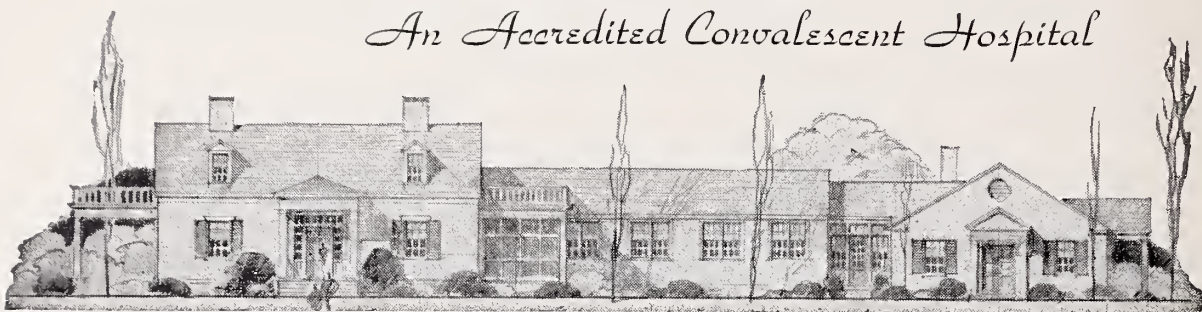


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the Public Health Committee: (1.) Endorsement of the present policy of the Public Health Department relative to the allocation of state and federal funds to communities for the assistance in construction of hospitals and public health centers. (2.) Endorsement of an A.M.A. Resolution No. 16 at the St. Louis Clinical Session in regard to the Manion Commission.

3. *Authorized* the chairman of the Hospital Committee to appoint two physicians to serve with the Executive Secretary on a proposed Joint Hospital Commission, composed of representatives from the Georgia Hospital Association, the MAG and two Nursing Associations.

4. *Approved* a request that the Woman's Auxiliary assist in recruiting and providing scholarships for student nurses.

5. *Authorized* expenses for a delegate to attend the AMA Rural Health Conference in Dallas, Texas, March 2-5.

6. *Approved* request by Civil Preparedness Committee to set up the present Medical Civil Preparedness Committee as technical advisory group to the State Civil Defense Health Services Division.

7. *Referred* request of Maternal Welfare Committee to send delegates to Obstetrical Conferences in Florida and North Carolina to the new Council for the reason that both of these meetings take place after the Annual Session in May.

8. *Approved* request by Industrial Health Committee to send a delegate to the AMA Industrial Health Conference, Louisville, Kentucky, February 2-5.

9. *Approved* request of AMEF Committee to send a delegate to the AMEF Annual Meeting in Chicago January 24 with all expenses to be paid by the A.M.A.

10. *Approved* the 1954 MAG program and platform as follows: Adequate physician care, voluntary insurance plan to be supported by all members, increased financial support for medical education, increased doctor placement facilities, support of Better Health programs.

11. *Instructed* the Executive Committee of Council to act with a joint committee from the Fulton County Medical Society to consider changes in the Academy building that would provide additional office space for the Association headquarters.

12. *Instructed* the Committee on Constitution and By-Laws to consider certain changes in the MAG Constitution and By-Laws.

Atlanta Graduate Assembly

Many of the nation's leading physicians will be guest speakers at the annual meeting of the Atlanta Graduate Medical Assembly at the Biltmore Hotel, February 22, 23 and 24, according to an announcement by Dr. Harold P. McDonald, Chairman.

Highlighting the program, Dr. McDonald said, will be symposia on Gastro-enterology, Cardiology, Isotopes and Obstetrics and Gynecology.

Among the guest speakers will be Dr. O. T. Clagett, Head of Section on Thoracic Surgery, Mayo Clinic, Rochester, Minn.; Dr. Elmer Belt, Director of the Elmer Belt Urologic Group, Los Angeles, Calif.; Dr. Charles A. Doan, Dean, College of Medicine, Ohio State University, Columbus, Ohio; Dr. Virgil S. Counsellor, Head of Section in General and Gynecological Surgery, Mayo Clinic, Rochester, Minn.; Dr. Donald D. Matson, Neuro-surgeon, Children's Hospital, Boston, Mass.; Dr. Carl Muschenheim, Associate Professor of Clinical Medicine, Cornell Medi-

cal School; New York, N. Y.; Dr. R. L. Sanders, Director of Sanders Clinic, Memphis, Tenn.; Dr. J. W. McCall, Chief, Dept. of Bronchoscopy and Esophagoscopy, Huron Hospital, Cleveland, Ohio and Dr. Edgar R. Pund, President, Medical College of Georgia, Augusta, Ga.

Dr. McDonald said that general practitioners interested in qualifying for recognition by the American Academy of General Practice are especially invited to attend the three-day meeting. Post-graduate credit will be given by the AAGP for such attendance, he explained.

The Atlanta Graduate Medical Assembly, sponsored by the Fulton County Medical Society, was held twice in Atlanta before World War II as the Atlanta Post Graduate Medical Assembly. The series of lectures making up the Assembly were started again in 1947, and have continued since that time under the sponsorship of the county medical group.

ANNOUNCEMENTS

FEBRUARY 1: Carroll-Douglas-Haralson Medical Society will meet at 7:30 p.m. at the home of Dr. J. W. Watts, Bowdon.

FEBRUARY 1-3: American College of Surgeons, Section Meeting, Charlotte, N. C.

FEBRUARY 2: Spalding County Medical Society will meet.

FEBRUARY 2: Fulton County Medical Society Health Forum, Tower Theater. "You and Your Operations," with Carl C. Aven, moderator.

FEBRUARY 3-6: American College of Radiology, Drake Hotel, Chicago.

FEBRUARY 8: DeKalb County Medical Society will meet at 7:30 p.m. at Pritchetts Restaurant or the DeKalb County Health Building.

FEBRUARY 9: Appling County Medical Society will meet at 7:30 p.m. at the Appling General Hospital, Baxley.

FEBRUARY 9: Tift County Medical Society will meet at 7:30 p.m. at the Tift County Hospital.

FEBRUARY 9: Georgia Medical Society will meet at 8:30 p.m. at the Society Hall, Savannah.

FEBRUARY 11: Habersham County Medical Society will meet at 7:30 p.m. at the Commercial Hotel, Cornelia.

FEBRUARY 11: Coffee County Medical Society will meet at 8 p.m.

FEBRUARY 12: Atlanta Radiological Society will meet at 8 p.m. at the Academy of Medicine.

FEBRUARY 17: Whitfield County Medical Society will meet at 7:30 p.m. at the Hamilton Memorial Hospital.

FEBRUARY 17: Atlanta Society of Psychiatry and Neurology will meet at 8 p.m. at the Academy of Medicine.

FEBRUARY 18: Tenth District Medical Society will meet at Athens.

FEBRUARY 22: Atlanta EENT Society will meet at 8 p.m. at the Academy of Medicine.

FEBRUARY 23: Richmond County Medical Society will meet at 7 p.m. at the Old Medical College.

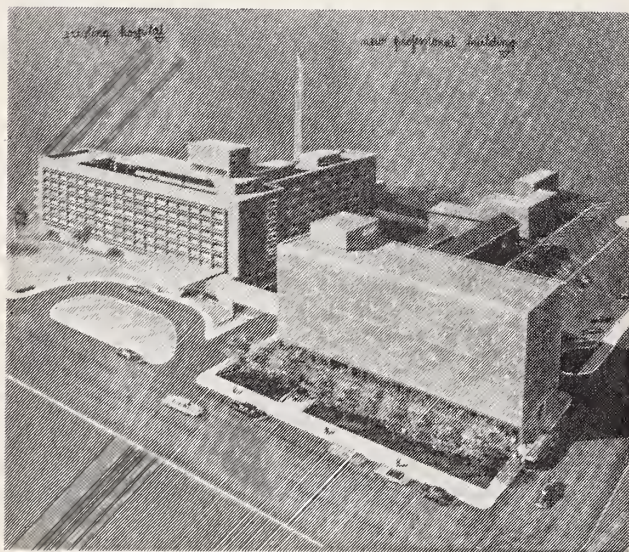
FEBRUARY 23: Muscogee County Medical Society will meet at 7:30 p.m. for dinner at the Standard Club, Columbus.

FEBRUARY 23: MAG Committee on Constitution and By-Laws will meet at 7:30 p.m. in the Oak Room of the Capitol City Club, Atlanta.

FEBRUARY 24: Atlanta Clinical Society will meet at 8 p.m. at the Academy of Medicine, Atlanta.

MARCH 4: Fulton County Medical Society regular meeting. Panel program, "Management of Disease Complicated by Diabetes."

MARCH 5-6: Spring Meeting of the Georgia Society of Ophthalmology and Otolaryngology at the General Oglethorpe Hotel, Savannah. Speakers will be Dr. Paul Chandler, Boston; Dr. A. B. Reese, New York; Dr. Henry P. Wagener, Rochester, Minn.; Dr. L. R. Boies, Minneapolis, Minn.; Dr. Francis LeJeune, New Orleans, La. and Dr. J. H. Maxwell, Ann Arbor, Mich.



Professional Building Wins Award

The design by Stevens & Wilkinson, Atlanta architects, for the proposed Georgia Baptist Hospital professional building in Atlanta has won an Award Citation (Commerce Category) in an architectural design competition conducted by *Progressive Architecture*, national architectural magazine. The structure is part of the expansion program under way at Georgia Baptist.

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From where I sit
by Joe Marsh

The Missus Keeps Posted

Ever since our electricity was cut off last year on account of me forgetting to mail in the payment, the Missus has been sort of leery about giving me letters to mail.

First, she'd ask if I mailed them, then double-check my coat at night. Then she stopped—and I figured she was sure I'd learned my lesson.

Then yesterday, I got a postcard at the office—from the Missus herself! It read: "Thanks, Joe, for mailing my letters." Well! Looks like she figured I *still* needed some checking-up and slipped that postcard in the last batch of letters.

From where I sit, an occasional check-up is a good thing. Like a check-up on our tolerance, for instance. I promise not to tell you what beverage to drink or how to practice your profession. Now I like a glass of beer with supper, you may 'prefer tea—but if I try to switch you to my choice, please "address" me with a reminder of your rights.

Joe Marsh

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SOCIETIES

Fulton County Medical Society celebrated its 49th Anniversary Banquet January 7 at the Atlanta Athletic Club. John W. Turner became the new president succeeding William G. Hamm. Principal speaker was Mr. Lewis F. Gordon of Atlanta. C. C. Aven announced that a new Fulton County Medical Society Cup for Community Service will be presented annually to the member of the medical society who makes the most outstanding contribution in the fields of welfare, education, health, governmental boards and the arts. Twenty-five year certificates were presented to L. Minor Blackford, Charles W. Daniels, Shelley C. Davis, I. H. Etheridge, Claude Griffin, J. T. Hutchins, William H. Kiser, Roy H. McClung, William O. Martin, Jr., Jack C. Norris and Herbert L. Treusch.

Georgia Medical Society held its annual Presidents' Dinner December 17 at the Hellenic Community Center, Savannah. Guests of honor were Howard J. Morrison, retiring president, and L. M. Freedman, incoming president. Samuel F. Rose was named president elect and other officers elected were T. A. Peterson, vice president; William W. Osborne, secretary and Ralph O. Bowden, treasurer.

Glynn County Medical Society met December 14 in Brunswick. Haywood Moore was named president, Frank Mitchell, vice president and James M. Hicks, secretary. Robert Creighton was named MAG delegate and Joseph Mercer, alternate delegate.

Habersham County Medical Society met recently at the Toccoa Country Club in conjunction with the Stephens County Medical Society. Guest speaker was W. H. Calvin, chairman of the department of Anesthesia at Emory University School of Medicine, Atlanta. New officers elected were: L. G. Hicks, Jr., Clarkesville, president; A. J. Walter, Sautee, vice president; F. O. Garrison, Demorest, secretary-treasurer. Board of censors, Thomas Lumsden, Helen



Pictured together at the Fulton County Annual Banquet are, left to right, Wm. P. Harbin, William G. Hamm, John W. Turner and B. L. Shackleford.

and George T. Nicholson, Cornelia. MAG delegate, J. J. Arrendale, Cornelia and alternate delegate, C. M. Henry, Clarkesville.

Hall County Medical Society recently elected Herbert Valentine president. Other new officers are P. F. Brown, Jr., vice president; Oliver Ghent, secretary-treasurer and Cullen McCarver and Rafe Banks, delegates to the MAG Annual Session.

Thomas County Medical Society met December 16 at the Glen Arven Country Club, Thomasville. Charles H. Watt, Jr., president, presided. Appearing on the program were Robert S. Major, George Dillinger and Oscar Mims. Julian Neel, secretary-treasurer, was in charge of arrangements.

Tri-County Medical Society, Carroll-Douglas-Haralson Counties, met December 7 at Tanner Memorial Hospital. A record attendance of 26 was recorded. New officers are R. L. Berry, Villa Rica, president; J. W. Watts, Bowdon, president-elect; J. H. Pritchett, Bremen, vice president; Francis Parks, Carrollton, secretary-treasurer and Claude Van Sant, Jr., Douglasville, and C. H. Allen, Bremen, delegates.

Meeting of MAG Committee

The second meeting of the Committee on Constitution and By-Laws will be held in the Oak Room of the Capitol City Club, Atlanta, Tuesday night, February 23 at 7:30 p.m. Members of the Association

are invited to send in suggestions, or present them in person, for changes or amendments to the Constitution and By-Laws. Allen H. Bunce, M.D., Chairman, Committee on Constitution and By-Laws.

PERSONALS

Samuel S. Ambrose, Atlanta, announces the opening of his offices at 34 Seventh St., N.E., Atlanta, for the practice of urology.

C. L. Ayers, Toccoa, has announced that he intends to enter the race for the State Senate from the 31st District next year.

R. L. Carter, Thomaston, has announced his retirement after 33 years of practice in Thomaston.

Vincent J. Cirincione, Savannah, announces the opening of offices at 800 Abercorn Street, Savannah, for the practice of dermatology. He recently returned from duty with the armed services.

Hal Conner, Dublin, announces the opening of offices in the Clinic Office Building, Eastman.

Ellison R. Cook, Savannah, has been named president elect of the Georgia Heart Association. Other new officers include *Goodloe Y. Erwin*, Athens, vice president; *Lamont Henry*, Atlanta, secretary and *Mr. James D. Robinson, Jr.*, Atlanta, treasurer. Directors elected for three-year terms were *Clarence C. Butler*, Columbus; *W. F. Hamilton*, Augusta; *Mr. Louis Harris*, Athens; *Miss Lucy Harris*, Winder; *Msgr. T. James McNamara*, Savannah; *Mr. Elfred S. Papy*, Atlanta and *Henry H. Tift*, Macon. *Harry H. Brill*, Columbus was elected to serve a two-year unexpired term.

Joseph B. Cooley, Decatur, announces the opening of offices at 2348 Glenwood Ave., Atlanta.

Walter G. Crawley, Marietta pediatrician, was invited by the United Cerebral Palsy Association to attend the Southern Regional Meeting which was held in Miami, Florida, January 9-10.

John K. Davidson, Columbus, is editor of the new Bulletin of the Muscogee County Medical Society. Associate editors are *Henry H. Brill*, *A. B. Conger*, *William C. Cook* and *Luther J. Roberts*.

D. B. Edwards, Pembroke, announces the opening of offices for the practice of medicine at Pembroke.

William G. Hamm, Atlanta, Fulton County Medical Society immediate past president, participated in dedication services for the new \$4,000,000 addition to St. Joseph's Infirmary, Atlanta.

A portrait of *Sam M. Howell*, Cartersville, was recently unveiled in the lobby of the Howell-Quillian Clinic, Cartersville, of which he was one of the founders.

C. Stedman Glisson, Jr. and *C. Walter Coolidge*, both of Atlanta, announce the return from the Armed Forces of *Arthur A. Smith* and his re-entry into the practice of gynecology and obstetrics at 1102 West Peachtree St., N.W., Atlanta.

Franklin H. Goodwin, Atlanta, announces the removal of his office to 1010 West Peachtree St., N.W., Atlanta, for the practice of internal medicine.

William A. Hopkins, Atlanta, announces the removal of his office to 710 Peachtree Street, N.E., Atlanta, for the practice of thoracic surgery, cardiovascular surgery and broncho-esophagology.

Henry S. Jennings, Gainesville, has opened offices at 608 East Broad Street, Gainesville, for the practice of internal medicine.

T. H. Lamson, Arlington, announced recently that the Arlington City Hospital has been approved by the American Medical Association.

E. C. Leaphart, Jesup, has been named chairman of the Wayne County Unit, American Cancer Society.

Julian L. Lokey, Thomson, has accepted the position of Medical Director of the Caswell School of Kingston, North Carolina, in charge of teaching and clinical research in the department of internal medicine.

Thomas A. McGoldrick, Savannah, was recently elected president of the Staff of St. Joseph's Hospital. Other officers are *M. M. Schneider*, vice president; *Mr. W. W. Osborne*, secretary and *G. W. Goldenstar*, treasurer.

Enrique Montero, Griffin, has been named director of the department of anesthesia, Griffin-Spalding County Hospital.

Jack C. Norris, Atlanta, is author of the recently published "Gleanings from a Doctor's Eye."

J. J. Pilcher, Louisville, was admitted recently as a patient at the Jefferson Hospital in Louisville. He is suffering from a heart condition.

R. W. Richardson, Macon, was recently married to Mrs. Frances Campbell Hughes, Atlanta, in Atlanta.

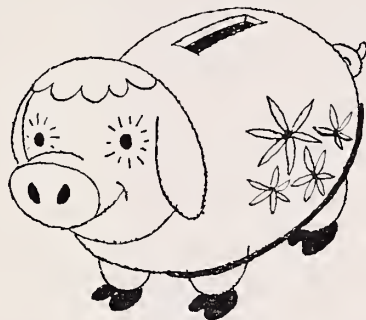
James Roberts, Sandy Springs and his wife, *Dr. Jessie Roberts*, have opened offices recently on Roswell Road for the general practice of medicine.

O. W. Roberts, Carrollton, was recently named president of the Tanner Memorial Hospital staff. Other new officers are *E. V. Patrick*, vice president; *Francis Parks*, Secretary-treasurer. Chiefs of services are *E. C. Bass*, surgery; *W. E. Thomason*, medicine; *R. L. Denney*, eye, ear, nose and throat; *Irving de Garis*, dental surgery and *Dr. Patrick*, scientific service.

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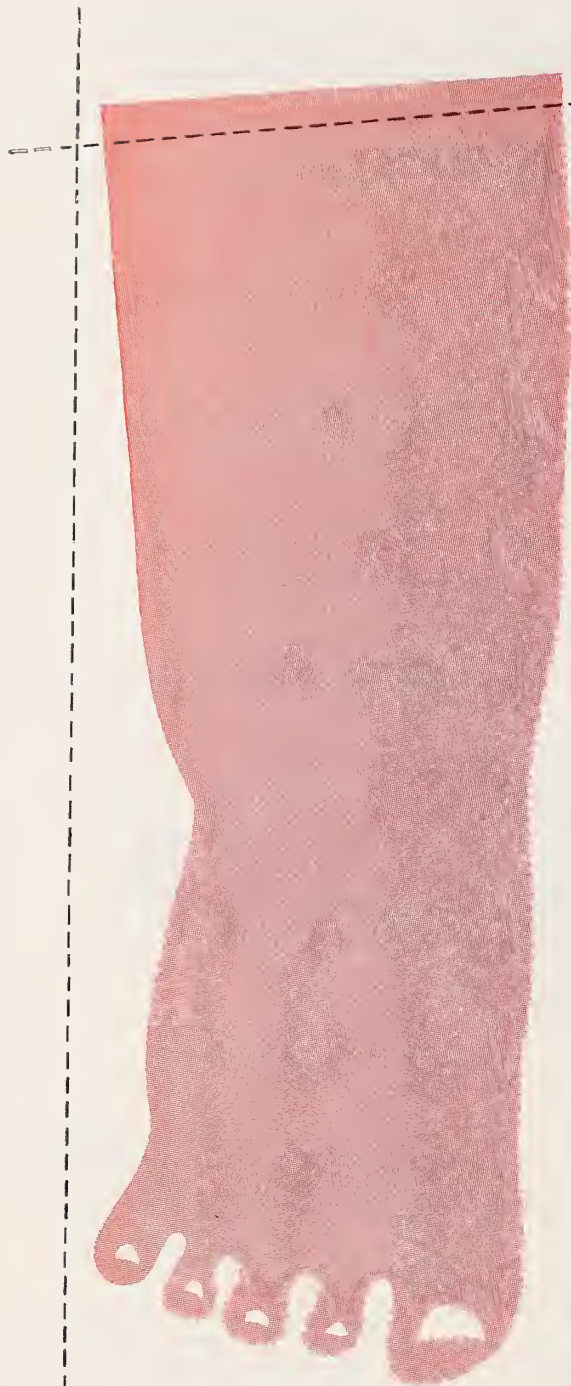
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*Stead, E. A., Jr., in Cecil, R. L., and Loeb, R. F.: Textbook of Medicine, ed. 8, Philadelphia, W. B. Saunders Co., 1951, p. 1065.

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Carter Smith, Atlanta, co-chairman of the Piedmont Hospital Building Fund's Memorial Gifts Committee, announced recently that the committee recently received a gift of \$30,000 from the estate of the late Dr. and Mrs. William F. Shallenberger. Two of the hospital's delivery rooms will be dedicated to their memory.

Robert A. Sears, Atlanta, announces the opening of his office at Suite 814, Doctors Building, Atlanta, for practice limited to neurological surgery.

L. V. Strickland, Cobbtown, was recently elected mayor of that town.

O. R. Styles, Cedartown, left recently for an ex-

tended vacation in East Lake Weir, Fla. He has practiced medicine in Cedartown for 13 years.

T. O. Vinson, DeKalb Health director, spoke recently on a panel at the Decatur Rotary Club meeting. Others on the panel were *Chester Morse*, *T. E. McGeachy* and *C. E. Cunningham*, all of Decatur.

William G. Whitaker, Jr., Atlanta, was one of the Georgia physicians appearing on the program at the First Section Meeting of the American College of Surgeons at Charlotte, N. C., February 1-3. Others included *John D. Martin*, Atlanta; *S. A. Wilkins, Jr.*, Atlanta, and *Peter B. Wright*, Augusta.

J. W. Yeomans, Jesup, has moved into his new office building at 241 Macon Street.

DEATHS

CATRON: Isaac T., 80, Atlanta, died December 23 in an Atlanta hospital. He lived at 16 Avondale Pl., N.E. Born in Barbourville, Ky., Dr. Catron was a graduate of the St. Louis College of Physicians and Surgeons. He served during the Spanish-American War with the Fourth Kentucky Infantry in Cuba. He was a member of the board of stewards of Grace Methodist Church and was a veteran member of the Fulton County Medical Society.

COLEMAN: Y. R., Jonesboro, died December 3. A native of Fayette County, he was graduated from the old State Normal School at Athens in 1897 and from Emory Medical School in 1908. He had practiced for a number of years at Macon where he served as city councilman and city physician.

DANIEL: John W., 84, Savannah, died January 1, 1954. He was one of the first physicians in the nation selected to use insulin in the treatment of diabetes and also did pioneer work on Bright's disease and reported the first successful cure of it in 1941. A native of Burke County, he was a past president of the Medical Association of Georgia and the Georgia Medical Society and served on the State Board of Health. A graduate of the University of Georgia and the Georgia Medical School, Dr. Daniel began practice in Savannah in 1896. He volunteered for Army service in World War I and served as a major in the Medical Corps. He was the author of several well-known papers on diets, insulin, gastric diseases and nephritis. He was past

commander of Chatham Post 36, American Legion and was a Mason.

KING: William Russell, Sr., 68, Tennile, died December 9 at a Macon hospital. He was a native of the Red Hill Community in Franklin County and practiced medicine in Crawford before moving to Tennile more than 30 years ago. He was the father of Dr. William R. King, Jr. and Dr. Harry King, both of Griffin, and Dr. Lamar King of Atlanta.

McCORD: Mather Marvin, 76, Rome, died December 14 at a hospital in Rome. He had practiced pediatrics in Rome for 39 years. He was the first pediatrician in the area, going to Rome in 1914. He was the county's first commissioner of health and had served for 10 years on the State Board of Health. He was graduated from Emory University School of Medicine and also attended the Medical College of Georgia. He served as Councilor for the 7th District Medical Society and was a past president of the Floyd County Medical Society, the 7th District Medical Society and the Floyd County Emory Alumni Society.

MOORE: Henry McIntosh, 66, Thomasville, died December 29 at his home on Remington Ave. He attended the University of Georgia and the Atlanta College of Physicians and Surgeons. He was a member of the T. L. Spence, Jr. Post of the American Legion, the Housing Authority of Thomasville and was a director of the Commercial Bank and the Thomasville Ice Co.

PATRICK: J. Z., 78, Pulaski, died December 28 at a local hospital. He had practiced medicine in the Pulaski Community of Candler County for his entire life. He was a Mason and was very active in community activities until his recent illness.

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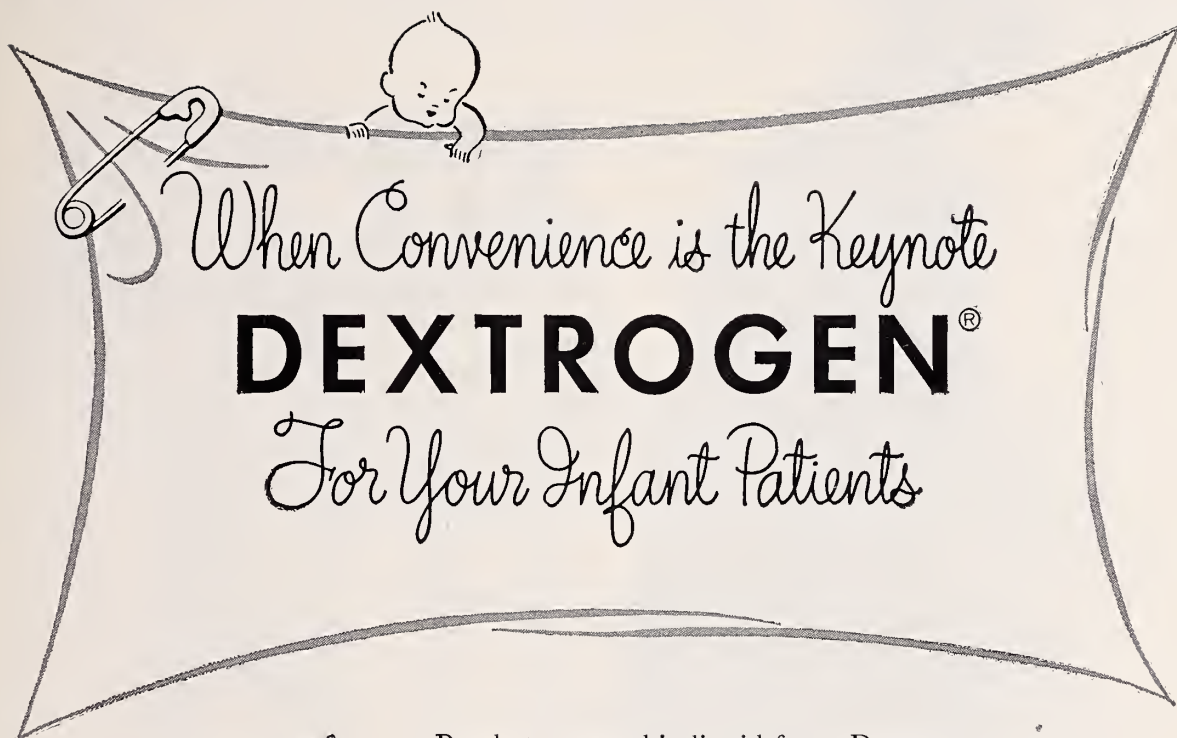
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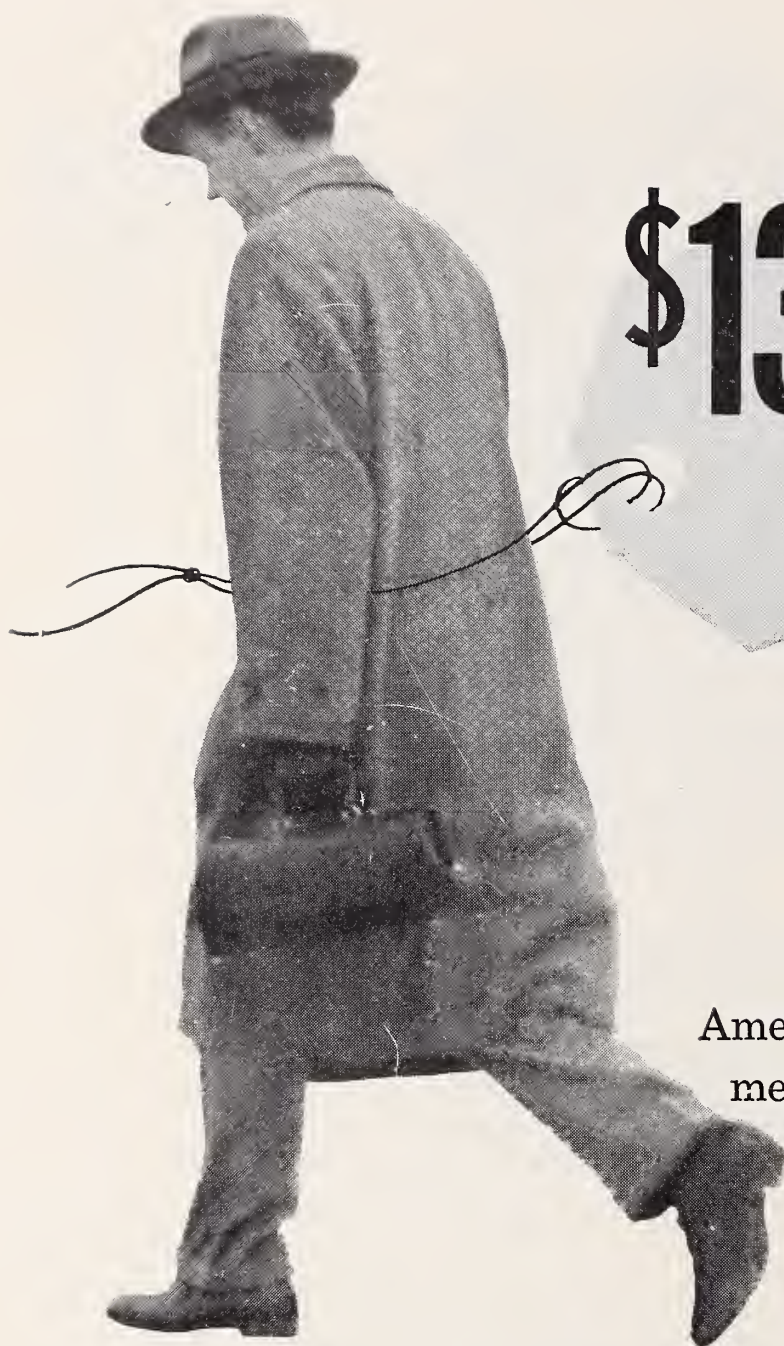
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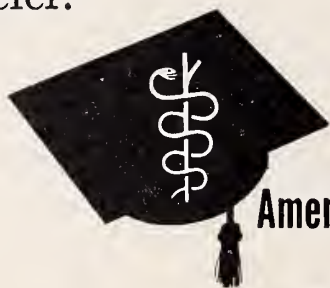
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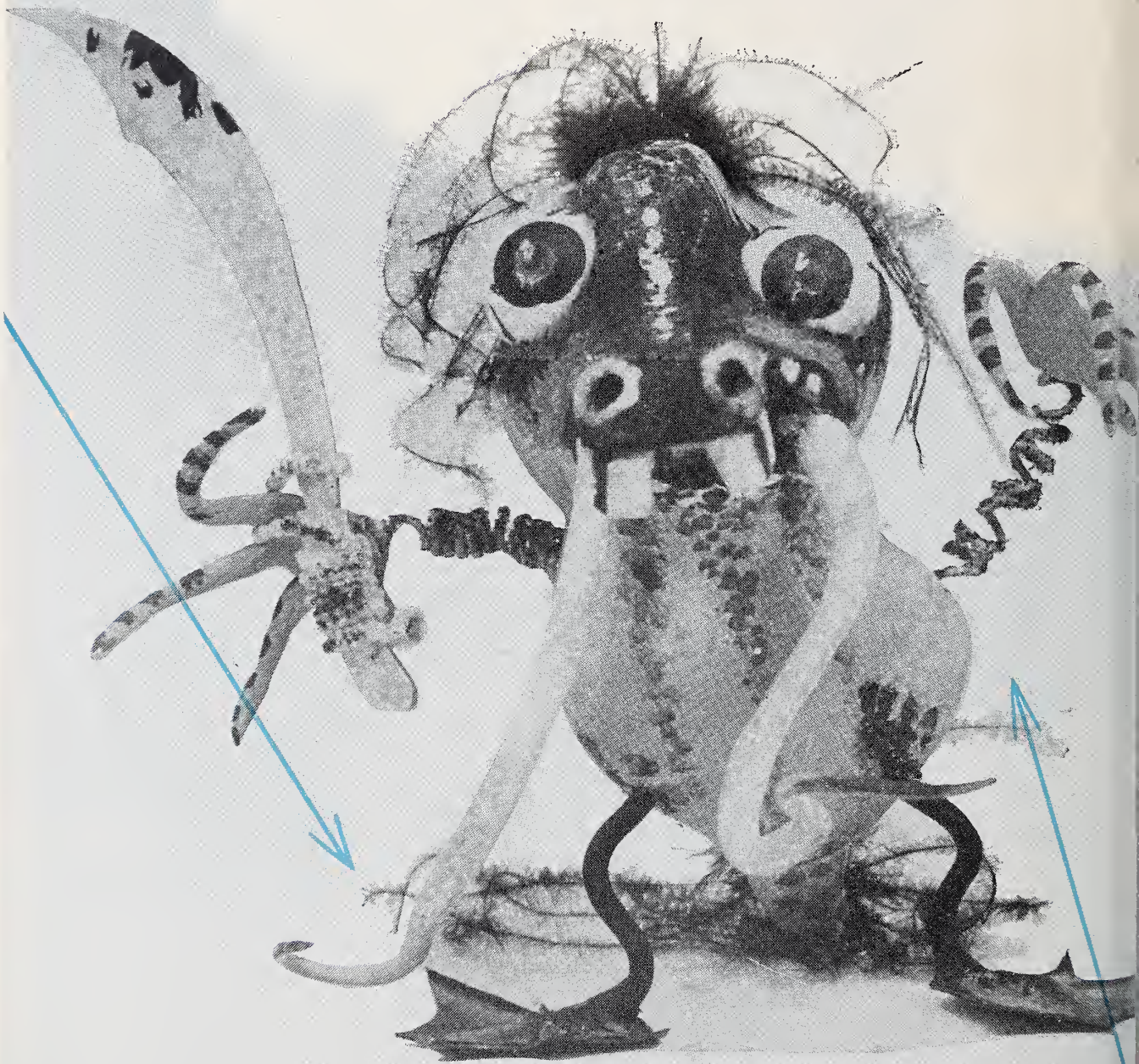
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1. Grigsby, M. E., et al., Antibiot. & Chemother., 10:1029, October, 1953.

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The JOURNAL of the *MEDICAL* *ASSOCIATION* *OF GEORGIA*

875 West Peachtree, N. E.
Atlanta, Georgia

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Articles are accepted for publication on the condition that they are contributed solely to this *Journal*. Manuscripts should be typewritten, double-spaced and the original, not the carbon copy, should be submitted. Receipt of manuscripts will be acknowledged and unused manuscripts returned. Used manuscripts will be returned only if requested.

STYLE

Ordinarily articles should not exceed 3,000 words. Only under exceptional circumstances will articles of over 4,000 words be published. Footnotes, bibliographies and legends should be typed on separate sheets, double-spaced. Bibliographies should conform to the style of the Quarterly Cumulative Index published by the American Medical Association—i.e., name of author, title of article, name of periodicals with volume, page, month, day of month if weekly and the year. They should be listed in alphabetical order and numbered in sequence. Example: 1. Jones, S. R.: Spontaneous Epistaxis, *Arch. Int. Med.*, 36:434 (Dec.) 1946.

NEWS NOTES

District and County Medical Societies, Association members and readers are invited to send in any news items of general concern to members of the Medical Association of Georgia.

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Illustrations, tables, etc., should bear the author's name and figure number. Used photographs, drawings and cuts will be returned after publication only if requested. The cost of reproduction of illustrated material for publication will be borne by the author and the engraver will bill the author for this expense.

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The Editor and members of The *Journal* Editorial Board will permit authors to have as wide a latitude as the general policy of the *Journal* and the demands on its space permit. The right to reduce, revise, or reject any material submitted for publication is always reserved. The *Journal* is not responsible for statements made by any contributor. All communications regarding editorial, advertising, subscription and miscellaneous matters should be sent The Editor, 875 West Peachtree Street, N.E., Atlanta, Ga.

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All advertising copy approved by the Councils of the American Medical Association shall be acceptable for publication. Other advertising copy may be accepted subject to the approval of the Editor and members of the Editorial Board. All copy or plates must reach the *Journal* office by 10th of the month preceding publication. General and classified advertising rates will be furnished on request.

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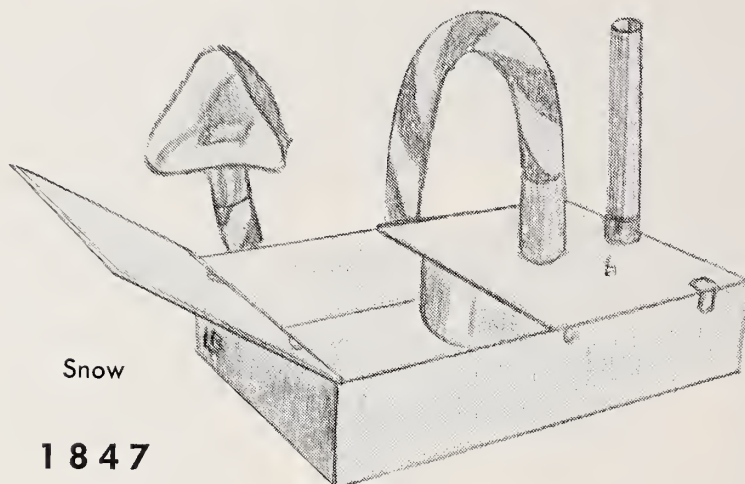
If in the opinion of the *Journal* Editorial Board, material submitted for publication could be improved by a Medical Editing Service, the Editor will contact the author for his approval. Association members needing assistance in preparation of material for publication may also use this service. A reasonable charge is made for this service and the cost of this will be borne by the author.



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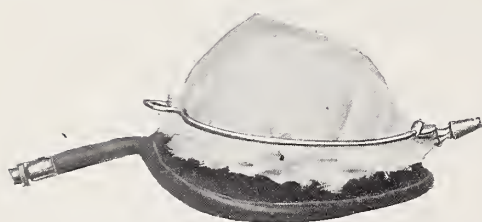
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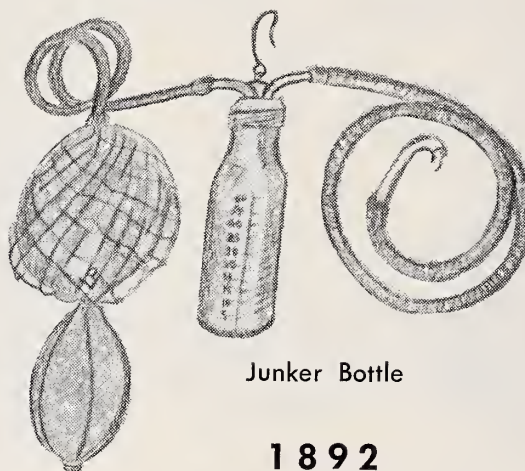


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1847



Gwathmey Yankauer Mask

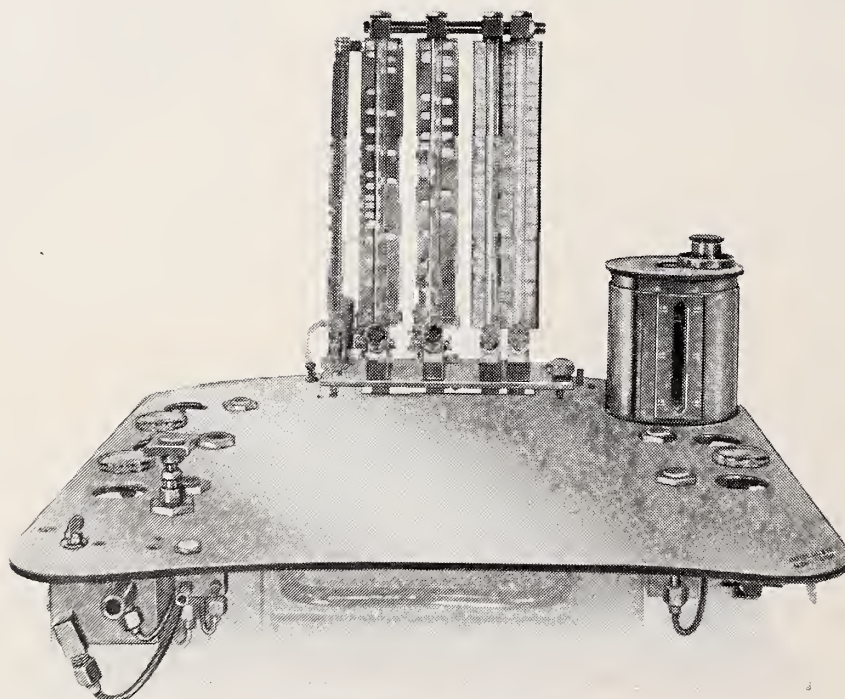


Junker Bottle



Gwathmey Mask

1892



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1952

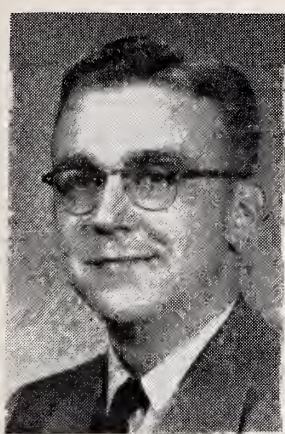
FOREGGER

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Journal of The Medical Association of Georgia

Crawford W. Long Memorial Issue



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THELMA FRANKLIN, Business

THIS ISSUE IS dedicated to the greatest discovery of mankind, the anesthetic properties of ether, and to the Georgian who made this discovery, Dr. Crawford W. Long. In the space allotted is an account of Anesthesia as it has advanced since that time, and the present day status of some agents, other than ether, in use at this time. The cover photograph and the photograph on page 194 are by Ted F. Leigh, M.D.

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The JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA, established 1911. Owned, edited and Copyright, 1954 by the Medical Association of Georgia, 875 West Peachtree Street, N.E., Atlanta, Georgia. Published monthly under the direction of the Council of the Association. Subscription rates: \$5 per year; 1 per single copy. Entered as second-class mail at the post office at Atlanta, Georgia, under the Act of March 3, 1879. Accepted for mailing for the general rate of postage provided for in Section 1103, Act of October 6, 1917, authorized November 14, 1928.

mag county society officers


SOCIETY	PRESIDENT	SECRETARY	MEETINGS
Altamaha	Edwin Virusky, Baxley	J. B. Brown, Baxley	Second Tuesday
Baldwin	J. E. Baugh, Milledgeville	Wilbur Scott, Milledgeville	
Bartow	Harry B. Bradford, Cartersville	A. L. Horton, Cartersville	Irregularly
Ben Hill-Irwin	W. D. Willcox, Fitzgerald	R. D. Roberts, Fitzgerald	
Bibb	Milford B. Hatcher, Macon	Henry H. Tift, Macon	First Tuesday
Blue Ridge	L. C. May, Blue Ridge	T. J. Hicks, Sr., McCaysville	First Monday
Brooks	A. B. Jones, Jr., Quitman	Harry A. Wasden, Quitman	Irregularly
Bulloch-Candler-Evans	John H. Barksdale, Jr., Statesboro	Helen Reed Deal, Statesboro	Second Tuesday
Burke	W. C. McCarver, Vidette	C. Thompson, Jr., Waynesboro	First Friday
Carroll-Douglas Haralson	R. L. Berry, Villa Rica	F. M. Parks, Carrollton	First Monday
Georgia (Chatham)	L. M. Freedman, Savannah	W. W. Osborne, Savannah	Second Tuesday
Chattooga	W. V. Hyden, Trion	Wm. P. Martin, Summerville	First Friday
Cherokee-Pickens	Ben K. Looper, Canton	A. M. Hendrix, Canton	Last Friday
Clarke-Madison-Oconee	John H. T. McPherson, Athens	John D. Elder, Athens	Irregularly
Clayton-Fayette	T. J. Busey, Fayetteville	Helen F. Sams, Fayetteville	Third Thursday
Cobb	E. S. Marks, Marietta	E. P. Inglis, Marietta	First Monday
Coffee	R. L. Johnson, Douglas	Sage Harper, Douglas	Second Thursday
Colquitt	P. D. Conger, Moultrie	E. C. Holmes, Moultrie	Second Tuesday
Coweta	J. O. St. John, Newnan	J. W. Parks, Jr., Newnan	
Crisp	C. E. McArthur, Cordele	Perry Busbee, Cordele	Second Tuesday
Decatur-Seminole	H. B. Baxley, Donalsonville	M. A. Ehrlich, Bainbridge	Four a Year
DeKalb	C. W. Morse, Decatur	W. E. Bloomer, Decatur	Second Monday
Dooley	V. C. Daves, Vienna	Martin L. Malloy, Vienna	
Dougherty	P. L. Hilsman, Albany	J. S. Inman, Jr., Albany	Fourth Thursday
Elbert	D. N. Thompson, Elberton	C. A. Mickel, Jr., Elberton	Second Tuesday
Emanuel	C. E. Powell, Swainsboro	R. J. Moye, Adrian	
Floyd	Ralph Davis, Rome	S. S. Smith, Rome	Third Tuesday
Forsyth	R. H. Bramblett, Jr., Cumming	J. S. Mashburn, Cumming	
Franklin	Stewart D. Brown, Jr., Royston	E. T. Poole, Lavonia	
Fulton	John W. Turner, Atlanta	Tully T. Blalock, Atlanta	First Thursday
Glynn	Hayward Moore, Brunswick	J. M. Hicks, Brunswick	Third Monday
Gordon	Byron Steele, Fairmount	C. K. Richards, Calhoun	Fourth Monday
Grady	A. W. Rehberg, Cairo	J. V. Rogers, Cairo	
Gwinnett	Reuben E. Smith, Buford	Robert Young, Lawrenceville	First Thursday
Habersham	L. G. Hicks, Jr., Clarksville	F. O. Garrison, Demorest	First Thursday
Hall	H. E. Valentine, Gainesville	O. T. Ghent, Gainesville	First Tuesday
Hancock	H. L. Earl, Sparta	D. E. Tanner, Sparta	Inactive
Hart	Geo. T. Harper, Dewy Rose	Louis G. Cacchioli, Hartwell	
Jackson-Barrow	A. A. Rogers, Commerce	C. B. Skelton, Winder	Monday After Third Sunday
Jasper	Marvin L. Green, Monticello	E. M. Lancaster, Shady Dale	Irregularly
Jefferson	Geo. S. Pilcher, Louisville	Walter J. Revell, Wadley	Second Wednesday
Jenkins	Q. A. Mulkey, Millen	A. P. Mulkey, Millen	First Friday
Laurens	W. M. Watkins, Dublin	J. P. Roche, Dublin	
McDuffie	A. G. LeRoy, Thomson	Paul H. Wilson, Thomson	Third Tuesday
Meriwether-Harris	J. W. Smith, Manchester	R. B. Gilbert, Manchester	Irregularly
Mitchell	E. M. Walker, Pelham	A. A. McNeil, Jr., Camilla	Annually
Montgomery	W. M. Moses, Uvalda	J. W. Palmer, Ailey	Irregularly
Morgan	C. H. Dickens, Madison	W. C. McGeary, Madison	
Muscogee	G. M. Hutto, Columbus	A. B. Conger, Columbus	Fourth Tuesday
Newton	R. M. Paty, Jr., Covington	Clarence B. Palmer, Covington	
Ocmulgee	E. G. Jones, Eastman	J. L. Thomson, Eastman	Last Tuesday, Quarterly
Polk	Richard Campbell, Cedartown	C. B. Teal, Jr., Cedartown	Fourth Tuesday
Rabun	L. Neville, Dillard	J. C. Dover, Clayton	Irregularly
Randolph-Terrell	E. A. Mayo, Richland	R. B. Martin, III, Cuthbert	Second Friday
Richmond	Harry D. Pinson, Augusta	J. L. Mulherin, Augusta	Fourth Tuesday
Screven	W. G. Simmons, Sylvania	K. R. Hawkins, Sylvania	Third Friday
South Georgia	Robert Perry, Valdosta	J. H. Brannen, Valdosta	Second Tuesday
Spalding	A. P. Jones, Griffin	Ann D. Stuckey, Griffin	Third Tuesday
Stephens	W. H. Good, Toccoa	C. L. Ayers, Toccoa	First Thursday
Sumter	A. C. Primrose, Americus	Henry R. Fenn, Americus	Irregularly
Tattnall	J. M. Hughes, Glennville	A. G. Pinkston, Jr., Glennville	Second Wednesday, Quarterly
Taylor	R. C. Montgomery, II, Butler	E. C. Whatley, Reynolds	
Telfair	C. J. Maloy, McRae	D. B. McRae, McRae	First Monday
Thomas	Charlie Watt, Jr., Thomasville	Julian Neel, Thomasville	Third Wednesday, Quarterly
Tift	E. M. Flowers, Tifton	W. L. Bridges, Jr., Tifton	Second Tuesday
Toombs	C. W. Finley, Vidalia	R. H. DeJarnette, Vidalia	
Tri-County (Calhoun, Early, Miller)	T. W. Rentz, Colquitt	Thomas H. Lamson, Colquitt	Third Wednesday
Troup	W. B. Fackler, Jr., LaGrange	Wm. L. Hutchinson, LaGrange	
Upson	Pruett Woodall, Thomaston	W. J. Gower, Thomaston	First Tuesday
Walker-Catoosa-Dade	T. A. Cochran, Ringgold	E. M. Townsend, Ringgold	Last Tuesday
Walton	H. B. Nunnally, Monroe	Ernest Thompson, Monroe	Third Monday
Ware	C. M. Massey, Waycross	Arthur M. Knight, Jr., Waycross	First Thursday
Washington	W. S. Helton, Sandersville	E. G. Newsome, Sandersville	Third Monday
Whitfield	H. L. Erwin, Dalton	Hubert U. King, Dalton	Third Wednesday
Wilcox	NONE	J. D. Owens, Rochelle	Not Active
Wilkes	M. C. Adair, Washington	R. G. Stephens, Washington	Third Tuesday
Worth	H. G. Davis, Jr., Sylvester	W. P. Stoner, Sylvester	Third Wednesday



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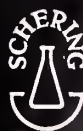


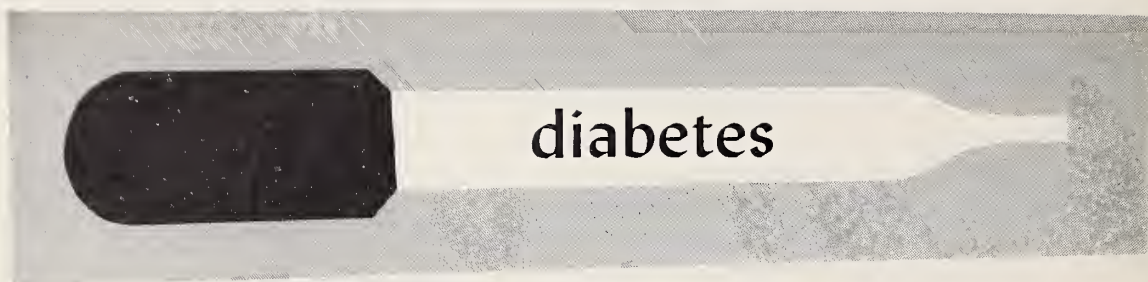
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"the ideal detection center is the office of the family physician"¹

Found: 20,255 "new" diabetics in one year in the private practice of 5000 physicians responding to a nationwide poll.* Of these, 81% were detected by urine-sugar analysis; 62% of the physicians used *Clinitest*.

Only 19% of the diabetics in this survey were detected by findings other than glycosuria. "Every patient therefore, should have at least one urinalysis as part of his examination, even if the purpose of his visit is only the removal of wax from the ears."²



for detection of urine-sugar

***Data from nationwide poll: Diabetes in daily practice**

70% were over 40.

40% had a family history of diabetes.

65% were overweight.

1. Blotner, H., and Marble, A.: New England J. Med. 245:567 (Oct. 11) 1951.

2. Steine, L.: GP 8:45 (July) 1953.



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Adjuncts in clinical management

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president's page

The dedication of this issue of the *Journal* of the Medical Association of Georgia to Crawford W. Long is one more tribute to the physician who was first to use ether for surgical anesthesia—one hundred and twelve years ago. This event is considered one of the major milestones in the history of scientific discoveries by our profession and has been called the greatest contribution to the development of modern surgery. Dr. Long's wish that his discovery be used to benefit mankind without monetary return to himself is more reason why Georgia should be proud of the fact that she can claim him as one of her native sons.

The Georgia Historical Commission is planning a memorial to Crawford W. Long on the site of his office in Jefferson, where the first surgical operation using ether as an anesthetic was performed. The Association has been asked to establish a museum and a center for disseminating free information to the general public as to current advances in medical science, after the memorial building has been completed. Under the proposed plan, we would assume the responsibility of the administration of the memorial. This will be another historical achievement for Georgia, which will be of much interest to the general public and of which physicians can be justly proud. It deserves your careful consideration as much time and money will be involved under the proposed plan.

The Woman's Auxiliary of the Medical Association of Georgia originated the observance of Doctors' Day and selected Crawford W. Long's birthday for this occasion. Following the lead of our Auxiliary, the nation has honored the medical profession on March thirtieth, and for this endeavor our "better-half" should be again highly commended.

WILLIAM HARBIN

editor's mail



To the Editor:

Pardon my delay in answering your request of January 11th for information concerning my activities in the Medical Association.

In 1946, Dr. Ed Greene, past president of the MAG came down and presented the award for twenty five years service as secretary of the Carroll County Medical Association. Since then Carroll, Douglas and Haralson Counties have united into the C-D-H Medical Association and four more years as secretary have been served.



Also served as president of the Carroll County Medical Association two years and as president of the C-D-H one term.

Represented the local association several times as delegate to the State Association and have represented the State as a fraternal delegate to other State Associations. Am a fraternal delegate to Alabama State this year, as you will note.

Was instrumental in getting the members of our association several years ago to pay a fee when they paid their annual medical dues, to be used for meals at the regular monthly meetings. This has proven to be a means of having a good attendance at most of the meetings since.

As to a biographical sketch, you may use any of these facts you wish. First, served on the committee to organize and write the Constitution and By-Laws of Emory Alumni and served on its first Board of Trustees. Have served as a member of the Board of Trustees of Georgia Baptist Hospital for thirty years.

Built and operated the Carrollton Clinic for several years. At that time the only hospital in Carroll County. Closed the Carrollton Clinic when we built the New Hill Burton Hospital in 1948. Then, served as first Chief of Staff of the new hospital.

Was Health Officer of the City of Carrollton and was Chairman of the Carroll County Board of Health for several years.

Served on the Board of Examiners during World War I and II and on the Board of Procurement and Assignment during World War II. Received the distinguished Service Award from Congress for unselfish service.

If there is any other information I can help you with, let me know.

Yours truly,

D. S. REESE, M.D.
Carrollton

To the Editor:

The Southern Pediatric Seminar would like to make the following announcements:

1. *Pediatrics and Internal Medicine*—July 12-24.
Obstetrics and Gynecology—July 26-31.
2. Registration on a weekly basis—\$25.00 per week.
3. A new ruling has declared all Seminar expenses tax deductible.

Of these new features, we are most proud and delighted to have Dr. Hugh Hussey, Editor of the G. P. Journal, to sponsor the two days of Internal Medicine. Dr. Hussey is procuring three other distinguished physicians to put on the program for July 16 and 17. We will write you more about this later on, but we are sure this will meet with an enthusiastic reception.

With kindest regards, I am

Sincerely yours,

D. Lesesne Smith
187 Oakland Avenue
Spartanburg, S. C.

To the Editor:

We would appreciate it if you would announce in the section of your Journal devoted to future meetings the time and place of the 1954 meeting of the American Goiter Association. This meeting will be held at the Somerset Hotel, Boston, Massachusetts, April 29, 30 and May 1, 1954.

The program for the three day meeting will consist of papers and discussions dealing with the physiology and diseases of the thyroid gland.


Sincerely,


John C. McClintock, M.D.
Recording Secretary.




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That's a Picker girder cassette frame he's struggling to twist out of true. Try it on a run-of-the-market x-ray cassette and you'd find the frame "weaving" all over the place.

Sturdy Picker cassettes don't depend on the bakelite front for stiffening, nor resort to similar skimping at other vital points. Ingenious hinges let the soft-felted cover float gently down upon the film into even allover contact without grinding the screens. Lock-springs turn on lapped pivots that won't pull out. Even such a simple thing as the cover lift is a sturdy steel ring which flicks up at the touch of a finger.

Such fine construction is more expensive, but it pays off in the long years of effective service it underwrites. The knowing eye of an engineer would note and approve. Lacking it, you pretty much have to take cassettes (as well as many another x-ray accessory) on faith.



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Meat...

and Adequate Protein Nutrition of the Diabetic Patient

Although formerly it was considered desirable in diabetes mellitus to hold protein intake only slightly above minimal requirements in order to minimize metabolic activity, present day treatment recognizes distinct benefits resulting from liberal protein alimentation.¹ Generous allowances of protein heighten the patient's sense of well-being, improve vigor, and augment the organism's inherent protective forces.

For the adult diabetic, desirable daily allowances of protein range from 1 to 1.5 grams per kilogram of body weight.¹ To assure adequate amounts of protein for growth and maintenance in diabetic children, allowances should range from 2 to 3 grams per kilogram. Following acute episodes during periods of inadequate insulin treatment, the concomitant negative nitrogen balance calls for high protein feeding until lost nitrogen is restored.² Though caloric intake is restricted for correction of overweight, protein allowances remain unchanged.

Meat ranks high among the foods qualified to provide the desired amounts of protein in diabetic diets. In fact, meat—because its rich store of protein is of highest biologic value—may well contribute a large share of the diabetic's daily protein requirement.³

In addition, meat also provides important amounts of essential B vitamins and minerals. Its appetite appeal goes far in enabling the diabetic patient to stay on his prescribed diet.

1. McLester, J. S., and Darby, W. J.: *Nutrition and Diet in Health and Disease*, ed. 6, Philadelphia, W. B. Saunders Company, 1952, pp. 287-299.

2. Pollack, H., and Halpern, S. L.: *Therapeutic Nutrition*. Prepared with Collaboration of the Committee on Therapeutic Nutrition, Food and Nutrition Board, National Research Council, Publication 234, 1952, p. 56.

3. Cecil, R. L., and Loeb, R. F.: *A Textbook of Medicine*, ed. 8, Philadelphia, W. B. Saunders Company, 1951, p. 634.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.



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Running noses, sneezing, watery eyes, clogged-up nasal passages quickly yield to administration of Neo-Synephrine hydrochloride — a nasal decongestant of proved clinical value. Ciliary activity is nearly untouched, sting and congestive rebound are practically absent, and effectiveness is undiminished on repeated use throughout the cold season.



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- 0.25% Solution
- 0.25% Spray (unbreakable plastic squeeze bottle)
- 0.25% Solution (Aromatic)
- 0.5% Solution
- 1% Solution
- 0.25% Emulsion
- 0.5% Jelly

Among the Potent Hypotensives

Noteworthy
for its

SAFETY



Veriloid®

A selective alkaloidal extract (alkavervir fraction) of *Veratrum viride*, Veriloid presents these noteworthy features when a potent hypotensive agent is indicated. Its dosage forms provide notable flexibility in treatment.

- Biologic assay—based on actual blood pressure reduction in mammals—assures uniform potency and constant pharmacologic action.

- Blood pressure is lowered by centrally mediated action; there is no ganglionic or adrenergic blocking.

- Therapy is rarely, if ever, fraught with the danger of postural hypotension.

- Hypotensive action is independent of alterations in heart rate.

- Cardiac output is not reduced.

- Renal function, unless previously grossly reduced, is not compromised.

- Cerebral blood flow is not decreased.

- Cardiac work is not increased; tachycardia is not engendered.

- No dangerous toxic effects from oral administration, no deaths attributable to Veriloid have ever been reported. Side actions of sialorrhea, substernal burning, bradycardia, nausea, and vomiting (due to overdosage) are readily overcome

and thereafter avoided by dosage adjustment.

- In broad use over five years, literally in hundreds of thousands of patients, no other sequelae have been reported, whether Veriloid is given orally or parenterally.

- Tolerance or idiosyncrasy rarely develops; allergic reactions have not been encountered. Hence tablets Veriloid can be given for the long course of treatment required in severe hypertension.

- Continuing therapy with Veriloid has not led to interference with appetite or with excretory function.

- Because of its rapidly induced, prolonged action (6 to 8 hours), tablets Veriloid provide around-the-clock hypotensive effect from 4 doses daily, and usually prevent hypertensive "spiking" during the night.

- A notable safety factor in intravenous administration is: *the extent to which blood pressure is lowered is directly within the control of the physician.*

Tablets

Slow-dissolving, scored tablets in 2 mg. and 3 mg. potencies; produce gratifying response in many patients with moderate to severe hypertension; in fully 30% of patients this response can be maintained for long periods;¹ combination with other hypotensive agents greatly increases this percentage.² Initially, 9 mg. daily, in divided doses, not less than 4 hours apart, preferably after meals. Dosage to be increased gradually, by small increments, till maximum tolerated dose is reached. Maintenance dose, 9 to 24 mg. daily.

Solution Intravenous

For immediate reduction of critically elevated blood pressure in hypertensive emergencies such as hypertensive states accompanying cerebral vascular disease, hypertensive crisis (encephalopathy), toxemias of pregnancy; lowers blood pressure promptly, to any degree the physician desires, and with notable safety, since excessive hypotensive and bradycardic effects are readily overcome by simple means. Supplied in a combination package containing one 5 cc. ampul and a 20 cc. vial of diluent, and in boxes of six 5 cc. ampuls. Solution contains 0.4 mg. Veriloid per cc.

Solution Intramuscular

For maintenance of blood pressure in such critical instances, and for primary use in less critical situations not showing the same immediate urgency. Provides 1.0 mg. Veriloid per cc. in isotonic aqueous solution incorporating one per cent procaine hydrochloride. A single dose lowers blood pressure significantly, reaching maximum hypotensive effect in 60 to 90 minutes. By repeated injections (every 3 to 6 hours) blood pressure may be kept depressed for hours or days if necessary. In boxes of six 2 cc. ampuls. Complete instructions (dosage and administration) with every ampul of the parenteral preparations should be noted carefully.

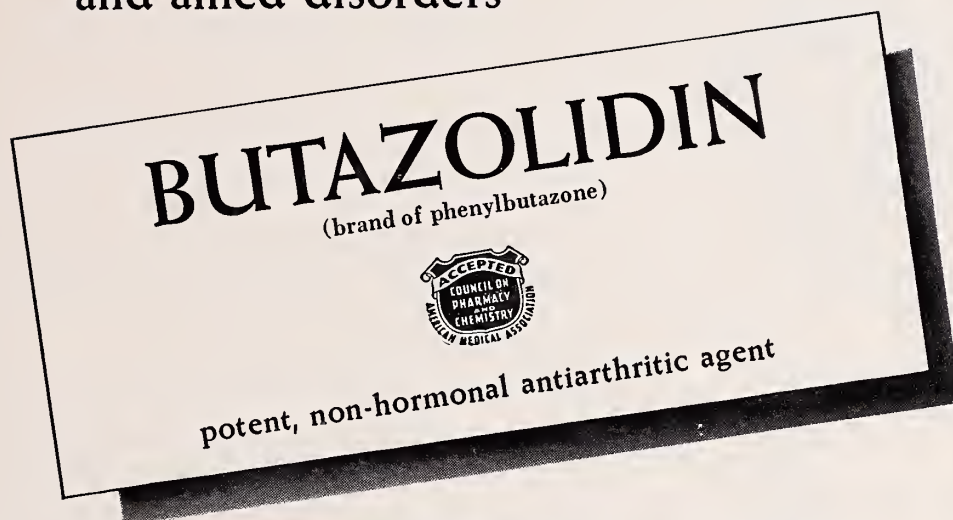
1. Kauntze, R., and Trounce, J.: Treatment of Arterial Hypertension with Veriloid (*Veratrum Viride*), *Lancet* 2:1002 (Dec. 1) 1951.
2. Wilkins, R.W.: Combination of Drugs in the Treatment of Essential Hypertension, *Mississippi Doctor* 30:359 (Apr.) 1953.

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in arthritis
and allied disorders



Its therapeutic effectiveness substantiated by more than fifty published reports, BUTAZOLIDIN has recently received the Seal of Acceptance of the Council on Pharmacy and Chemistry of the American Medical Association.

In the treatment of arthritis BUTAZOLIDIN produces prompt relief of pain. In many instances relief of pain is accompanied by diminution of swelling, resolution of inflammation and increased freedom and range of motion of the affected joints.

BUTAZOLIDIN is indicated in:

Gouty Arthritis	Rheumatoid Arthritis
Psoriatic Arthritis	Rheumatoid Spondylitis

Painful Shoulder (including peritendinitis, capsulitis, bursitis, and acute arthritis)

Since BUTAZOLIDIN is a potent agent, patients for therapy should be selected with care; dosage should be judiciously controlled; and the patient should be regularly observed so that treatment may be discontinued at the first sign of toxic reaction.

Physicians unfamiliar with the use of BUTAZOLIDIN are urged to send for complete descriptive literature before employing it.

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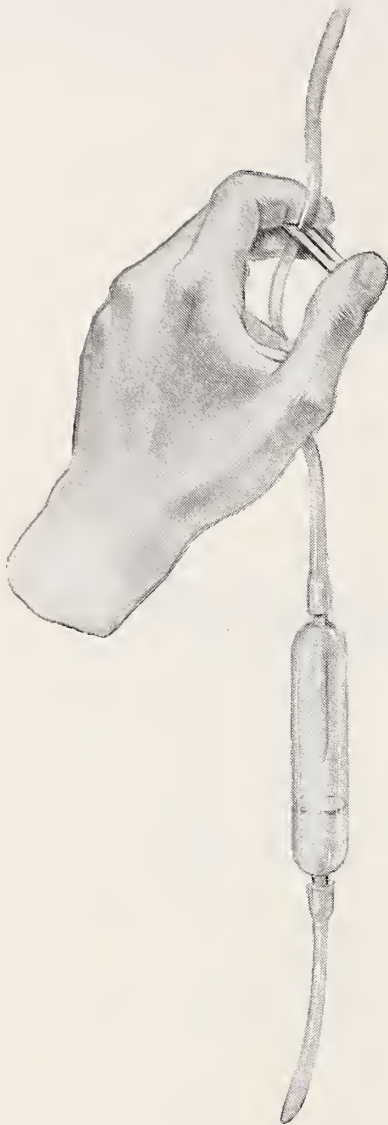


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control

*degree and duration
of muscle relaxation*

Controllability is the outstanding advantage of 'Anectine'. It is the result of rapid onset of action, followed by rapid inactivation of the drug by hydrolysis.

Response to alteration of the rate of flow of an intravenous drip of 'Anectine' is apparent in 30 to 60 seconds; therefore the rate required to provide adequate flaccidity, yet retain spontaneous respiration, is quickly determined. Relaxation can then be increased or decreased, within a matter of seconds, according to operative needs. Recovery of muscle tone begins immediately on stopping the infusion.

Speed, both in onset of action and recovery, characterizes single injections of 'Anectine'. So administered, it is dramatically effective for overcoming laryngospasm and for facilitating endotracheal intubation.

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SUCCINYLCHOLINE CHLORIDE



Injection . . . 20 mg. in each cc.
Multiple-dose vials of 10 cc.
Ready for intravenous injection.

Solution . . . 50 mg. in each cc.
Ampuls of 10 cc.
To be diluted for preparation of
intravenous drip solution.

For full information, write to —



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the executive secretary's letter

Dues—Dues—Dues

Your County Society Secretary has by now contacted you concerning local, state and AMA dues. If you have not remitted to him, the following paragraph from the MAG Constitution and By-Laws is brought to your attention.

Chapter VIII.—Dues and Assessments—“ . . . Any member whose name has not been reported for enrollment and whose dues for the current year have not been remitted to the Secretary-Treasurer of the Association on or before April 1st, shall stand suspended until his name is properly reported . . . ”

“ . . . An active member who fails to pay dues for one or more years shall be eligible for reinstatement upon payment of dues for the current year plus one year's dues in arrears subject to re-application and approval of his county society . . . ”

“ . . . For the purpose of medical defense a member shall be deemed in arrears from and during the period extending April 1st of the current year . . . ”

For final clarification MAG dues are \$25.00 and AMA dues are \$25.00. This sum must be remitted to *your county society secretary*, who will forward them to the MAG Headquarters office. Do not send any dues direct to the MAG but pay them to *your county society secretary*. April 1st is the deadline.

The Law Says

Prescriptions for narcotics must be *written*. According to the law, narcotic prescriptions cannot be transmitted orally. There is no provision in the Federal Narcotic law comparable to the oral prescription provision in the Food and Drug Administration Durham-Humphrey law. Nor can narcotic prescriptions be refilled. Each narcotic prescription must be a separate order and *written*. This means any telephone prescription for narcotics is *illegal*—except under extreme emergency conditions. Do not ask your pharmacist to violate the law—do not expect him to violate the law.

Reminder

For a County Medical Society to function in an orderly fashion it is a “must” to have an up-to-date Constitution and By-Laws to govern the so-

ciety. A County Medical Society is looked upon as a responsible official body in each community—an important unit in the health and welfare of the community. As such, its action and procedure often become public record. Secretaries of County Medical Societies should assess their situation in regard to this matter. The MAG Headquarters office will be glad to supply any Society with “model Constitution and By-Laws” data and render service in this capacity. Also, not to be overlooked is the importance of official minutes for every meeting taken as matter of record.

Delegates, 1954 Annual Session

Your MAG policy and planning represents the viewpoint of organized medicine in Georgia. Association action on all questions confronting Georgia medicine is approved or disapproved by your County Medical Society representatives in the MAG House of Delegates. The House of Delegates is the final authority that governs your state medical association.

Prior to Jan. 1, each County Medical Society must elect their Delegates and so inform the Headquarters Office so that credentials may be forwarded your delegates—as delegates will not be permitted to serve in the House of Delegates at the 1954 Annual Session without duly authorized credentials. From the MAG Constitution and By-Laws:

“Sec. 2. Each component society shall elect one delegate and a corresponding alternate for each 25 members, or fraction thereof, whose dues shall have been paid . . . ”

Your county medical society is urged to notify the MAG Headquarters office of your elected delegates immediately.

Top Men of Medicine

Invited as guest speakers for your 1954 Annual Session, Session, Macon, May 2-5, are the following guest speakers who will appear on the program:

Dr. Frank Brown Berry, Assistant Secretary of Defense and Professor of Surgery, N. Y. C.; Dr. Edward B. D. Neuhauser, Asst. Professor of Roentgenology, Harvard Medical School; Dr. Nelson K. Ordway, Professor of Pediatrics, Louisiana State University School of Medicine; Dr.

Edgar Hull, Professor of Medicine, Tulane University of Louisiana School of Medicine; Dr. Charles E. Irwin, Director, Warm Springs Foundation; Dr. Alice McNeal, Professor of Anesthesiology, Medical College of Alabama; Col. Harvey Slocum (MC), Walter Reed Hospital, USA; Dr. Arthur R. Colwell, Professor of Medicine, Northwestern University Medical School; Dr. Oscar Creech, Asst. Professor of Surgery, Baylor University College of Medicine; Dr. Walter B. Martin, AMA President-Elect; Dr. Franklin L. Payne, Professor of Obstetrics and Gynecology, University of Pennsylvania School of Medicine; Dr.

Cyrus C. Erickson, Professor of Pathology, University of Tennessee College of Medicine; and Dr. Homer Pearson, AMA Judicial Council Member.

1954 MAG Annual Session

Plans for a topflight Annual Session are in the mill and the word is out that attendance will be greater than ever. Physicians can plan on a well-rounded program tailor-made for the general practitioner as well as for the specialist. Mark the dates on your calendar now—May 2-5, Macon, Georgia.

Milton D. Krueger
Executive Secretary

the month in washington

Amend Hill-Burton Law

Washington, D. C.—Some parts of the Eisenhower administration's broad health program are making good progress on Capitol Hill, while others are virtually standing still or bogged down in the technical complications that are always a threat to new legislation. Well ahead of the other proposals, and possibly destined for enactment, are bills to broaden the scope of the Hill-Burton hospital construction law and to liberalize income tax deductions for medical expenses.

The House Interstate and Foreign Commerce Committee, under chairmanship of Rep. Charles Wolverton (R., N. J.), wound up its long fact-finding study of voluntary health insurance plans and immediately started hearings on the Hill-Burton changes. The purpose is to amend the Hill-Burton law so that it can be used to disburse federal grants to states for construction of health facilities that do not qualify as "hospitals". The administration is anxious to stimulate the building of more nursing homes, hospitals for the chronically ill, diagnostic or treatment centers and rehabilitation facilities.

Deduction of Medical Expenses

The House Ways and Means Committee, meanwhile, was giving its approval to a new income tax provision that would allow the deduction of medical expenses if they exceed 3% of adjusted gross income, rather than 5% under present law. The present maximum limitation would be doubled, and the deduction of travel expenses allowed where travel is prescribed by a physician. These changes—a long-time AMA goal—are embodied in the omnibus tax readjustment bill.

Voluntary Health Plans

President Eisenhower's proposal for federal reinsurance of voluntary health plans has not been able to follow the steady course on which it first appeared to be embarked. At the House hearings, none of the spokesmen for the large organizations in the health fields—AMA, Blue Cross and Shield, American Hospital Association—was willing to indorse the plan. Like the AMA spokesmen, most of them wanted first to examine the actual administration bill, which at that time had not been introduced. From the Blue Cross, however, came a suggestion that the idea be tried out experimentally.

Spokesmen for national labor organizations expressed mixed reactions, with some maintaining that reinsurance was a poor substitute for what they believe the country really needs—national compulsory health insurance.

Health Budget

The administration's health budget for the next fiscal year, starting next July 1, calls for a slight overall reduction. The regular Hill-Burton program, currently operating on \$65 million, would get \$50 million (any appropriation to start the proposed expanded construction would be in addition.) Relatively sharp reductions would be made in funds for venereal, tuberculosis and communicable disease control, in line with the policy of shifting this responsibility to the states.

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The Ascendancy

OCCASIONALLY THERE appears an article which delights the reader to the point of wishing that each of his associates could read it. Such was the case when I read Richard Gordon's "Sleeping Partner". It is reproduced here through the courtesy of Messrs. Bradbury, Agnew and Co., Ltd., London, in whose publication "*Punch*" it appeared in October 1953. Particular attention is called to the second sentence.

"Surgeons are traditionally accused by the medical profession of introducing two necessary evils—wound infection and anaesthetists. In the past hundred years both of these have fortunately become less dangerous to human life.

"When chloroform was still a novelty and gas a luxury, the anaesthetist was a seedy practitioner, a Coroner's familiar, creeping round hospitals and nursing homes with a rag of lint in one pocket of his coat tail and a bottle of ether in the other. With this equipment he could perform his shaky tricks instantly and anywhere, like a strolling conjurer. The surgeons took the limelight and ninety per cent of the fee: the anaesthetist at his best was only a Jeeves, ready to smooth the surgical progress of his master, to encourage him in clinical distress, and to temper discreetly his operative enthusiasms. He was a butt for all the hearty surgical fun that battens on blood and sterile towels—how relieved the nurses were when Sir Lancelet's wrath at a moving target was canalized into: 'If the patient can keep awake, Mr. Anaesthetist, so can you!' From his perch at the head of the table he yawned beneath his mask at weary accounts of forgotten anatomical battles, and he left the hospital by bicycle in the dust of the surgical limousine.

"As operations became longer and anaesthetists had more hours of comparative inactivity to meditate over their humility, they invented a scheme to assert their personalities in the operating theatre. The trick was simple: they repudiated the rag-and-bottle, and invented a machine a-glitter with chromium plate and taps to administer the

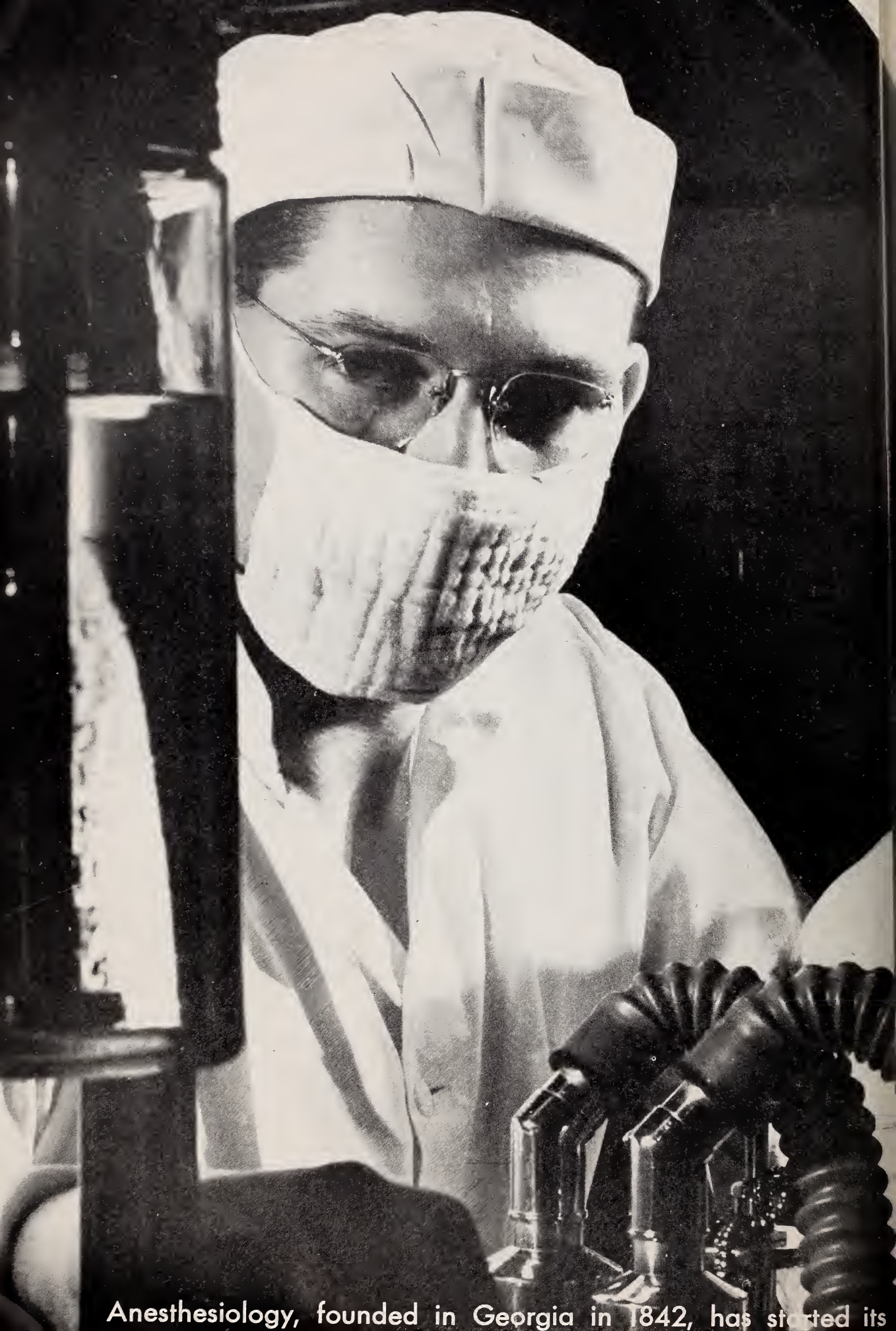
anaesthetic for them. At first the surgeons pretended amusement, and made jokes about 'The Gas, Fight, and Choke Company.' But they were mystified and intimidated, particularly when the anaesthetist strolled away for a cup of coffee and left his patient tranquilly free-wheeling. It had previously been plain to everyone in the theatre that any damn fool with a bottle and roll of lint could give anaesthetic, but even the dullest junior probationer could now see that the manipulation of this secret machine needed the fused skills of an engineer, pilot, and safebreaker.

"The anaesthetists coolly pressed their advantage. The machines became bigger and more aggressive, forcing the surgeon to operate uncomfortably in the remaining corner of the theatre. Anaesthetists boldly told their own stories across the towel clips, and the daily operating list ended politely with 'General Anaesthetic, Dr. Tompkins, please.' Surgeons who once began an operation by plunging knife into abdomen with a roar of 'Is he asleep, Bill?' waited patiently for permission, with sterile gloves meekly clasped. Afterwards they bowed over the swab bucket, as the anaesthetist neutralized his apparatus with a pair of spanners, and said 'Thank you, Dr. Tompkins—a very beautiful anaesthetic. We shall have the pleasure of working together next week, I presume?' Two limousines now left the hospital courtyard together.

"When surgeons and anaesthetists reunited after the war they were faced with problems of readjustment as powerful as those of any other long separated couple. The surgeons had seen Army doctors at work with squares of flannel and ether cans, and had learnt so much about lorries, guns, tanks, and radio sets from enthusiastic brother officers that they were no longer frightened of an anaesthetist's civilian equipment. But they were infuriated to find that anaesthetists had assumed the grand simplicity; heavy apparatus was pushed into theatre sister's store room, and modern anaesthesia conducted with a single syringe.

"This concentration in the anaesthetist's armament was permitted by purification of the curare arrow-poison from South America: the Brazilian

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Anesthesiology, founded in Georgia in 1842, has started its

110 Years of Anesthesia

JOHN S. LUNDY, M.D., Rochester, Minn.

JUST 10 YEARS AGO, Dr. Frank K. Boland, of Atlanta, Georgia, arranged for me to speak before the faculty and student body of the University of Georgia on the subject "One Hundred and One Years of Anesthesia." In that address, I stressed the work of Dr. Crawford W. Long (Fig. 1) and the things that followed his first use of ether for surgical operation on March 30, 1842.^{2,3} Doctor Boland and Doctor Long are no longer with us, but one must give Doctor Boland credit for his untiring effort to see that Doctor Long received full recognition for the first use of ether in a surgical operation. For devoting much of their lives to the field of anesthesiology, I wish to salute Doctor Boland and Doctor Long.

In the first 5 years after 1842, there was a great deal of emphasis on anesthesia. Then for a considerable period of time interest lagged in the latter part of the nineteenth century, but a very great deal has been accomplished in the first half of the twentieth century. A great deal of progress was made in the fifteen-year period from 1930 to 1945. I will be referring to this progress later on. There are certain historical efforts which appeared in my paper of ten years ago that I have been asked to retain, and I simply shall bring that paper up to date as well as I can.

Ether

One of the problems was, of course, to obtain a good quality of ether and a sufficient supply. Edward H. Squibb, in 1853, developed a revolutionary method for the manufacture of ether by the continuous passage of steam through lead coils. The next problem was to determine by what routes this anesthetic agent might be administered. Pirogoff, in Russia in 1847, described the administration of ether by rectum. However, the results were unsatisfactory because the agent was instilled undiluted. It was not until 1885 that Moliere, of France, again tried the rectal method of administration but once more it was discarded. The method was not used with success until 1913 when the late James T. Gwathmey, of the United States, was able successfully to anesthetize a patient by instilling into the rectum a mixture of ether and oil. No improvement in administration by this route has yet been developed, although Gwathmey himself felt that some form of gum rubber, such as latex, might be used as a vehicle for the ether and thus reduce the volume of material that the rectum must hold at one time for successful use of this method.

Another method of administering ether was tried by Ludwig Burkhardt of Germany in 1909 when he injected it into a vein. In 1913, William F. Honan and J. Wyllis Hassler reported the intravenous use of ether in 5 to 7.5 per cent solution. This method was useful but not very successful because of the large amount of vehicle needed for introduction of the ether. Further progress has not yet been made in this method of administering ether and probably will not be made until some vehicle can be obtained which will reduce the total bulk of solution to be administered, especially during a long operation.

The standard method for administering ether remains that of inhalation of vapor into the lungs. First, fumes from a saturated sponge or cloth were inhaled. Then containers were made from which the patient could draw air over the surface of the ether by putting his lips over a tube coming from the device. Eventually, masks covered with gauze were made to put over the face, and ether was dropped on the masks intermittently. This proved to be the most satisfactory method of administering ether. Eventually, an ether bottle was put on a gas machine and the closed method of combining ether vapor with gases was used. These two methods are extensively employed today, for ether remains the safest all-around agent for inhalation anesthesia.

Chloroform

Chloroform is seldom used in this country any more as an anesthetic largely due to the large present day choice of anesthetics and also because the emphasis in this field is in the direction of safety to such an extent that I foresee the era of anesthesia being followed by an era of analgesia. I do not mean to say that we will give up anesthesia altogether but that we will add, I hope, to our ability to use analgesics and increase greatly the safety factor that was difficult at times to control when drugs were given in insufficient doses to produce surgical anesthesia.

Nitrous Oxide

In 1867, the S. S. White Dental Manufacturing Company, of the United States, introduced an inhaler to cover the mouth and nose. The nitrous oxide was obtained from a large bag of the gas. However, the successful use of nitrous oxide came about through E. W. Andrews of Chicago, who introduced the use of oxygen with nitrous oxide. In 1871, the Johnston brothers compressed nitrous oxide into wrought iron cylinders. This packaged the gas. In 1876, Clover, of England, introduced the use of nitrous oxide for inducing anesthesia and the use of ether for maintaining anesthesia. In 1880, Klikovitch, of Russia, began the use of nitrous oxide in obstetric practice.

An early apparatus for mixing chloroform vapor and nitrous oxide was introduced by Hurd, of the United States, in 1899. During the next quarter century, many anesthesia machines were introduced. In 1912, Boothby and Cotton developed a machine, and in the same year one was devel-

oped by Gwathmey and Woolsey. In subsequent years, machines were manufactured and improved until at present they are vastly different from what they used to be.

Nitrous oxide, because it was noninflammable, proved very useful, especially to dentists. The addition of oxygen and ether to nitrous oxide made it even more applicable. A mixture of nitrous oxide and oxygen is often used to great advantage with other anesthetic agents. It has been widely adopted and, in general, it is the most useful anesthetic gas. I think it probably will hold this position for a long time. In 1910, J. A. Heidbrink developed "timed anesthesia" with nitrous oxide and oxygen. He made a good gas machine.

With the advent of effective analgesics, I foresee the time when they will be administered while the patient is inhaling 80 per cent nitrous oxide and 20 per cent oxygen. Preliminary medication will be used probably intravenously, immediately before operation, and will be followed by the administration of an analgesic such as MRD-125 (5-ethyl-6-phenyl-*m*-thiazane-2, 4-dione), which I first used on July 30, 1953. This agent produces marked analgesia of the skin. It does not cause the patient to lose consciousness entirely. Although he will be able to open his eyes and swallow on command, he will not remember much about the operation. The dose of the drug required to produce this effect when administered in conjunction with 80 per cent nitrous oxide and 20 per cent oxygen is only a third of the dose required to produce a similar effect when administered alone. It seems to be particularly useful for dental procedures. It has been used in about 100 cases at the Mayo Clinic. The results of its use in these cases will be reported elsewhere. This drug is hard to obtain, and it is difficult to dissolve and keep in solution. Although these difficulties will have to be overcome, we are fortunate enough to have had this drug long enough to permit us to obtain a conception of an era of analgesia. Chemists certainly will provide us with the necessary analgesic agents since their need now is apparent.

Ethylene

Ethylene was the anesthetic gas next introduced. It has been noted by Crocker and Knight, in 1908, that ethylene put flowers to sleep. Knight told Luckhardt about this gas and, in 1918, Luckhardt and Thompson discovered its anesthetic properties. In 1923, Luckhardt and Carter introduced the use of ethylene for the production of

From the Section of Anesthesiology and Intravenous Therapy, Mayo Clinic and Mayo Foundation, Rochester, Minn.

surgical anesthesia. In the same year, Brown, of Canada, also reported the use of ethylene as an agent for producing general anesthesia. Use of this agent became extensive immediately, and lasted until about 1935 or 1936. The agent is still used in many places. The inflammable and explosive property of ethylene makes its employment somewhat hazardous, although, in general, it is not considered to be more explosive than the mixture of nitrous oxide, oxygen and ether. Some ethylene is still used for obstetric procedures, but it seldom is used for other procedures.

Cyclopropane

The anesthetic gas, cyclopropane, was next introduced by Waters, Neff and Rovenstine, in 1933, and it has largely replaced ethylene. Although cyclopropane is inflammable and explosive, it is more potent than ethylene and, therefore, is easier to administer. Patient, surgeon and anesthetist are better satisfied with this agent than they are with ethylene. Successful clinical use of cyclopropane was dependent on another advance in general anesthesia, namely, the use of soda lime as an absorbent of carbon dioxide. Soda lime was first used in anesthesia by Jackson, of the United States, in 1915, in the laboratory, and was perfected and used clinically by Waters in 1923. It effected great economy because, since nitrous oxide, ethylene, cyclopropane and ether do not undergo chemical change in the body, they are just as good after being exhaled as they were when inhaled. To use them over and over again it was necessary to have only a tight-fitting mask and leak-proof, closed apparatus into which the patient might breathe. With this device, carbon dioxide can be withdrawn

and small amounts of oxygen added to keep the patient alive. The patient converts the oxygen into carbon dioxide, the soda lime removes the carbon dioxide and, theoretically, very small amounts of anesthetic agents would be needed. Cyclopropane was at first expensive, and this economical way of administering it made its clinical use possible on a wide scale. The necessity for economy has compelled manufacturers to supply all makes of gas machines with soda-lime absorbers.

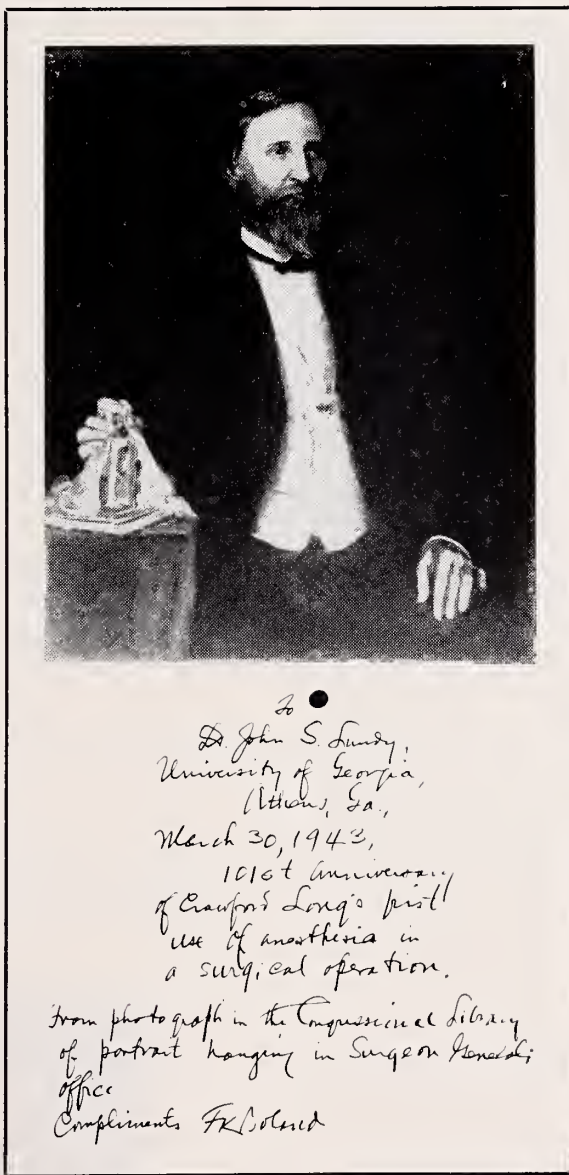
This has greatly influenced the style of the gas machine. Cyclopropane has been supplanted very largely for a variety of reasons by an intravenous anesthetic plus curare plus nitrous oxide and oxygen, preceded by preliminary medication.

Carbon Dioxide

Use of a mixture of carbon dioxide and oxygen was advocated in 1908 by Yandell Henderson for overcoming asphyxia for other purposes, but it was not used extensively until 1923, when Foregger constructed the Seattle model apparatus for me. Other manufacturers remodeled their machines from time to time and adapted them to present-day purposes. Because of competition, each manufacturer used special parts. Faulconer has succeeded in making an acoustic gas analyzer, together with various other devices, with which

he was able to demonstrate all the changes in the contents of the breathing bag on the gas machine, which I predicted might be done. Great improvement has come about through the pin-index system of fixing the gas machine so that the wrong cylinder cannot be put on a yoke.

Various drugs, especially morphine, were used in conjunction with the use of anesthetic agents,



in the hope that less of the anesthetic preparation would be necessary if additional drugs were used. Greene, in 1868, advocated the use of such drugs, and, throughout the years, some of these drugs have been employed. At present, the drugs most commonly used for this purpose are morphine, atropine, the barbiturates, scopolamine, methadon hydrochloride and demerol hydrochloride. Sometimes only one drug is used; at other times two or three drugs are used. While these drugs have not always seemed to be of value when used with inhalation anesthesia, they are of great value when used in combination with local and intravenous anesthesia. Nalline hydrochloride (N-allylnormorphine hydrochloride) will neutralize the effects of morphine. It, therefore, has increased the usefulness of this drug.

Endotracheal Anesthesia

The introduction of the endotracheal tube was a great contribution to the development of satisfactory inhalational anesthesia. As long ago as 1871, Friedrich Trendelenburg used this method of anesthesia. In 1878, Macewen, of Scotland, used a tube which was passed through the mouth into the trachea, but little attention was paid to employment of this method. In 1909, Meltzer and Auer, of the United States, used intratracheal insufflation in anesthetizing animals and, in the same year, Elsberg used it in anesthetizing a human being. What these men had done received considerable publicity, but it was not until 1920 that Magill, of England, really developed endotracheal anesthesia as it is known today. He used large, soft rubber tubes through which the patient could breathe readily and through which the anesthetist could ventilate the patient's lungs with whatever he wished to use. Waters, Guedel, Flagg and Tovell have made special tubes which have proved satisfactory.

An intrapharyngeal tube has been used a great deal. The tube is inserted, usually through the nose, to a point above the top of the trachea, but it does not enter the trachea. This tube has made it possible for the anesthesiologist to remove himself and his devices a sufficient distance from the field of operation so that the surgeon has all the room he needs to perform the operation undisturbed. The field of operation then is not contaminated by unsterile devices. This is especially important in operations on the head, face and thorax.

Intravenous Anesthesia

Intravenous anesthesia was originated in

France, in 1872, by Ore, who injected chloral hydrate intravenously. As time went on, other drugs were used for this purpose, but the present wide interest in intravenous anesthesia was revived in 1929 by Zerkow, of the United States, who used sodium amytal (sodium isoamyl-ethylbarbituric acid). Another step was made in 1931 when I reported the use of pentobarbital sodium (nembutal sodium) for intravenous anesthesia. In 1932, Weese and Scharpff introduced evipal sodium, which was the best agent used intravenously up to that time because its effect was very short. In 1934, I reported the intermittent method of administering pentothal sodium, and it has been the agent of choice since that time. It is brief in action and has proved to be useful in both military and civilian practice. Some authors have said that surital sodium [sodium 5-allyl-5-(1-methylbutyl)-2-thiobarbituric acid] is better than pentothal sodium but I have not found it so.

Local Anesthesia

Local anesthesia was first used in Bohemia in 1884, when Carl Koller used cocaine in the eye to produce surgical anesthesia. In 1885, Halsted of the United States, introduced nerve blocking with cocaine, and, in the same year, Corning, also of the United States, produced spinal anesthesia with cocaine. Development of lumbar puncture in Germany by Quincke, in 1894, was followed by the introduction of cocaine directly into the spinal

Biographical Sketch of the Author



John S. Lundy, M.D.

fluid by Corning. In 1899, Tuffier of Paris, used spinal anesthesia and, in the same year, Matas of New Orleans was the first surgeon in the United States to use it for a surgical operation. Since that time, various local anesthetic agents which are more satisfactory and safer than cocaine have been synthesized. With the widespread use of curare, there has been a marked decrease in the use of spinal anesthesia. The agent most used for spinal anesthesia is procaine hydrochloride, which often is called "novocaine," although metycaine hydrochloride is being used with increasing frequency partly because it is a surface anesthetic as well as an injectable anesthetic.

There are many other good local anesthetic agents, but I do not feel the need of them since I have both procaine hydrochloride and metycaine hydrochloride at hand. The duration of spinal anesthesia produced with procaine hydrochloride is not always sufficiently long but, in 1940, Lemmon, of Philadelphia, introduced a method called "continuous spinal anesthesia" in which the needle is left in place and, by means of a catheter, the anesthetic solution is injected into the spinal subarachnoid space and anesthesia is maintained for the desired period.

The use of local anesthesia has been a great boon in both dental and medical practice. Techniques have been developed for anesthetizing nerves in all parts of the body. These procedures

have been used for diagnosis and for the treatment of conditions usually associated with pain. In the last 10 years, roentgenography has been used to facilitate accurate placement of the needles in blocking nerves for diagnostic or therapeutic purposes.

Muscle Relaxants

Griffith first used curare to produce relaxation during operation and anesthesia in 1942,¹ and since that time curare has been used extensively and has greatly influenced the use of anesthetic agents and methods. The combination of pentothal sodium and curare administered intravenously plus the use of nitrous oxide and oxygen through an intratracheal tube eliminates the danger of fire and explosion. The patient is enthusiastic over the pentothal sodium because of the lack of unpleasantness in connection with its use. The surgeon appreciates the relaxation which can be had when desired, and the anesthesiologist appreciates being able to use a mixture of 50 per cent nitrous oxide and 50 per cent oxygen, or, in some cases, a mixture of 80 per cent nitrous oxide and 20 per cent oxygen. The introduction of such agents as tensilon chloride [(3-hydroxyphenyl) dimethyl ammonium chloride], which will neutralize the effects of curare, has increased the safety of administration of this drug.

Other relaxant drugs are succinylcholine chloride (diacetylcholine chloride), decamethonium bromide [decamethylenebis (trimethylammonium bromide)], dimethyltubocurarine iodide, and flaxedil [tri-(di-ethylaminoethoxy) benzene triethylidide]. Unless the throat is sprayed with a surface anesthetic before intubation, the laryngeal spasm will be more severe in cases in which curare is administered in conjunction with pentothal sodium than it will be in cases in which anectine chloride brand succinylcholine chloride is administered with the pentothal sodium.

The following summary appeared in a recent article by Virtue:⁴

"1. Curare, dimethylcurare, and Flaxedil act by preventing acetylcholine from depolarizing the motor end-plate muscle.

"2. Decamethonium and succinylcholine act by maintaining depolarization of the motor end-plate.

"3. Physostigmine antagonizes the effects of the curare-like relaxants by inhibiting cholinesterase. Tensilon is a shorter-acting antagonist of curare.

"4. Reliable antagonists to decamethonium

John S. Lundy, Senior Consultant, Section of Anesthesiology, Mayo Clinic, Rochester, Minn. and Professor of Anesthesiology, The Mayo Foundation for Medical Education and Research, Graduate School, University of Minnesota. Diplomate and Past President of The American Board of Anesthesiology; Fellow in Anesthesiology and Past President of The American Society of Anesthesiologists; Recipient of Distinguished Service Award of The American Society of Anesthesiologists, 1948; Secretary of Section on Anesthesiology of the American Medical Association; Member of American Society for Pharmacology and Experimental Therapeutics, International Anesthesia Research Society and Sigma Xi; Awarded Hon. Degree of LL.D., Hahnemann Medical College and Hospital, 1943 and D. Sc., University of North Dakota, 1948; Civilian Consultant to Surgeon of the Seventh Army, U.S.A.; appointed advisor on anesthesiology to the Shriners Hospitals for Crippled Children, 1953. Author of book, "Clinical Anesthesia"; has contributed over 300 articles to medical and professional journals.

and succinylcholine are not on the market at present."

Anesthesiology

The anesthesiologist has found his field gradually extending into almost all parts of the practice of medicine. He has been called on to assist both internists and surgeons with many of their problems, such as resuscitation, intravenous medication, and management of patients who have become uncontrollable through mental or physical difficulties.

The anesthesiologist, in his daily experience, has found it necessary to be able to deal with shock. Therefore, he has learned to administer blood, plasma volume expanders, and stimulants. He has had to understand the administration of oxygen with tents and masks, and the use of lighted instruments by means of which suction tubes can be placed so as to clear the air passages of foreign bodies and accumulated material. Foreign material becomes lodged in the air passages from time to time in the course of operation under general anesthesia and in connection with certain accidents in factories and other places.

As the field now designated as anesthesiology has developed over this period of 110 years, more and more physicians have limited their practice to this specialty. As a result, societies have been formed, magazines have been established, and many books have been written, all relating to this special field.

The first society of anesthetists was founded in London in 1893. Also, societies either exist, or did exist in Germany, Italy, France, the United States, Canada and several other countries. It may be of interest to know that the first university to grant an advanced degree in anesthesiology was the Graduate School of the University of Minnesota. The Long Island Society of Anesthetists was organized by Adolph Erdmann in 1903. It later

became the New York Society of Anesthetists and then the American Society of Anesthesiologists. Within the American Society of Anesthesiologists there is now a section called the American College of Anesthesiologists which offers a fellowship certificate after a written and oral examination. Fellows in the American College of Anesthesiologists do not have to limit their practice entirely to anesthesiology as do the diplomates of the American Board of Anesthesiology. It was not until 1937 that the American Board of Anesthesiology was established. This board certifies physicians considered to be qualified specialists in the United States and Canada and, in June of 1941, the Section on Anesthesiology of the American Medical Association held its first meeting.

At present, the military services continue to make a real effort to see that they have available men who are able to administer anesthetic agents satisfactorily. There is an equal need in civilian life for such persons. It can be predicted that there is a splendid prospect for those persons who enter this field of medicine. Frequently, young people feel that the practice of medicine has been so nearly perfected that there is little opportunity for them. However, the contrary is the case; that is, medicine is making rapid advances and has done so for many years. This is exemplified by the special field of anesthesiology which, after being founded in Georgia in 1842, is now starting on its second century.

Mayo Clinic

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Health Council's Newsletter

The Better Health Council of Georgia is sending out its first newsletter in February. Health items of interest to the citizens of Georgia will be featured. Of particular interest will be a column devoted to special projects in local health councils such as the awarding of scholarships for further

study in the field of health, assisting with the hearing and vision testing in the schools, and many others. Send news notes to the Better Health Council of Georgia, 875 West Peachtree, N. E., Atlanta, Ga., by May 10 for the next quarterly publication which will appear late in May.

Cyclopropane --- an Evaluation

A QUARTER OF A CENTURY has gone by since the first patient was anesthetized with cyclopropane by Ralph M. Waters.¹ In the interim this anesthetic agent has been subjected to extensive laboratory and clinical study.² The preponderance of the published reports in favor of cyclopropane is unquestioned. The unbiased and experienced anesthesiologist today considers cyclopropane a valuable addition to his armamentarium and an indispensable anesthetic agent in the presence of hemorrhage, shock, debility, or in any poor risk patient.

This evaluation is based on twenty years of personal experience in over 40,000 anesthetics in which cyclopropane was the chief agent. During this span of time cyclopropane has been employed alone or in combination with other anesthetic drugs in a large variety of surgical procedures. Involved were patients of all ages and many races in physical states varying from the poorest to the best of anesthetic risks. The experience of the personnel managing the anesthetics varied from the partially or well supervised uninitiated to the well trained anesthesiologist.

In this evaluation no attempt will be made to give minute details regarding the administration of cyclopropane.

For pre-anesthetic premedication we employ short acting barbiturates two hours before anesthesia followed by proportionate dosages of demerol and scopolamine 30 to 60 minutes later.

From the Department of Anesthesiology, Medical College of Georgia, Augusta, Georgia.

We rarely exceed 75 mgm of demerol in our adult males and 50 mgm in our adult females. Proportionately lower dosages are given to children. Atropine replaces scopolamine in infants under one year of age and in adults over 65 years of age.

The ultra short acting barbiturates (evipal, pentothal or surital) are almost routinely used for induction of anesthesia with cyclopropane except

in the extreme poor risk or the child under ten years of age who will not cooperate. The barbiturates are given slowly intravenously to avoid a respiratory depression which might lead to an inability to obtain a concentration of the cyclopropane sufficient for surgical anesthesia without considerable delay or resorting to controlled

breathing. When cyclopropane is used for induction we still resort to the original technique recommended by Waters³ of starting with a low concentration of the drug and gradually increasing until a desired depth of anesthesia is obtained. If this simple technique is adhered to, laryngospasm need not occur. Bronchospasm usually due to heavy concentrations should be a rarity. If either does occur, a reduction of the concentration of the agent will invariably immediately improve the situation.

The carbon dioxide absorption technique is still employed by us with cyclopropane in children above four years of age.

In younger children a semi-open technique employing a combination of nitrous oxide three to four liters per minute, cyclopropane 25-300 cc per minute, and oxygen one and one-half to three

Review of Cyclopropane Based on Two Decades of Personal Experience

liters per minute is generally used. A Stephen non-rebreathing mask or an adaptation of this mask is employed if the trachea is not to be intubated. In the event endotracheal intubation is desired a Leigh or Stephen-Slater non-rebreathing valve is employed with the flows of gases as given above. If assisted or controlled respirations are necessary we prefer to revert to the carbon dioxide technique employing a to and fro 90-180 gram canister.

Cyclopropane is our most commonly used inhalation maintenance anesthetic agent. This applies to all types of surgical procedures including intra-thoracic (pulmonary or cardio-vascular), intra-abdominal and neurosurgical.

The introduction of the skeletal muscle relaxants during the past decade has been a particularly useful adjuvant for cyclopropane. This is true whether one wishes to employ the longer acting drugs of this type such as tubocurarine chloride or the shorter acting ones such as decamethonium bromide or succinylcholine chloride.

Cyclopropane can be employed as the main agent for endotracheal intubation. However, when one of the muscle relaxants (succinylcholine chloride or decamethonium bromide) is given in addition, intubation can be more readily performed without the tendency of laryngospasm or bronchospasm or both. This applies to all patients, children as well as adults. Our present policy is to employ evipal and decamethonium bromide or succinylcholine chloride for routine endotracheal intubations followed by nitrous oxide-oxygen until respirations are well established. In the event a supplement to this is needed cyclopropane is the usual supplemental agent.⁴ This applies to children as well as adults.

For obvious reasons cyclopropane is not recommended as the primary agent for emergency surgery in children with full stomachs, unless endotracheal intubation is part of the technique.

The main controversy concerning cyclopropane has revolved around the following: (1) cardiac arrhythmias; (2) rise in blood pressure during anesthesia; (3) increased oozing of blood at the operative site; (4) a drop in blood pressure in some patients following the withdrawal of the anesthetic; (5) the tendency toward increased reflex autonomic activity in some patients (laryngospasm and bronchospasm), and (6) the hazard of fire and explosions.

Biographical Sketch of the Author



Perry P. Volpitto, M.D.

CARDIAC ARRHYTHMIAS: Moderate bradycardia (60-70) with cyclopropane is a well known routine occurrence, usually of no significance. If this is aggravated to a degree producing a pulse below the low fifties we may see a sudden tachycardia followed by an arrhythmia. This is an indication for immediate lightening of the anesthesia. The administration of moderate doses of atropine intravenously (0.2 to 0.4 mgm) will abolish the bradycardia, but this is not necessary if the desaturation technique is followed. In our experience we have encountered all types of arrhythmias *with the exception of ventricular fibrillation* during cyclopropane anesthesia. We neither employ nor recommend prophylactic measures to combat these arrhythmias. Our clinical experience has corroborated Waters's experience in dealing with cardiac arrhythmias with conservative concentrations as a preventative and desaturation technique for therapy. With this approach we do not believe heart disease to be a contra-indication to the use of cyclopropane.

RISE IN BLOOD PRESSURE DURING ANESTHESIA: This is generally not an annoying complication. It also occurs with other anesthetic agents. It is thought to be due to an accumulation of carbon dioxide. A high concentration of oxygen has also been suggested as possibly interfering with the normal transport of carbon dioxide. An adequate tidal and minute volume of respiration coupled with adequate but not unduly excessive concentra-

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tion of oxygen may reduce the incidence of high blood pressure during cyclopropane anesthesia. Respiratory obstruction with accompanying hypoxia should always be ruled out.

INCREASED OOOING OF BLOOD AT THE OPERATIVE SITE: This is not an uncommon occurrence whenever gaseous agents and the carbon dioxide absorption technique or a semi-closed technique with partial rebreathing are employed. An increase in CO_2 may be contributory. Avoidance of hypoventilation and excessive oxygenation may reduce this annoying but not hazardous complication.

A DROP IN BLOOD PRESSURE IN SOME PATIENTS FOLLOWING THE WITHDRAWAL OF CYCLOPROPANE: This is thought to be primarily due to an accumulation of CO_2 during the anesthetic with a decrease in pH and a rise in pCO_2 .^{5 6} At the termination of the procedure the patient's pCO_2 rapidly drops within a very short time after the mask or endotracheal tube is removed. The usual findings are a lowered blood pressure, a slow pulse, a warm and dry skin and subcyanotic mucous membranes. Disorientation may be seen, but not routinely. More commonly the patient appears "washed out" but will respond to simple questions. We have seen a picture similar to this during the recovery from other anesthetic agents. With the adequate replacement of blood volume during the anesthetic it has been our impression that this phenomenon was not as frequent and certainly not hazardous. Our therapy consists of: elevation

of the foot of the bed and keeping a vein open with five per cent glucose in distilled water. If the blood pressure drops a third or more of the usual normal a small dose of a vasopressor, usually neosynephrine 0.5 mgm, is given intravenously and repeated if necessary. An intravenous drip of neosynephrine five to ten mgm per 500 cc of five per cent glucose in distilled water may be titrated in rare instances of protracted hypotension. We have seen no deaths attributable to this type of blood pressure drop per se.

THE TENDENCY TOWARDS INCREASED SINO-AORTIC OR VAGAL MECHANISM: This condition is usually seen as a tendency towards bronchial constriction or laryngospasm or both. This may occur in adults but more frequently is encountered in children. Adequate premedication with atropine or scopolamine may reduce this incidence. Lowering of the anesthetic concentration will definitely improve the constrictive tendency. The administration of nitrous oxide with cyclopropane in children will either completely avoid or reduce this hazard to a negligible minimum.

FIRE AND EXPLOSIONS: This is a hazard which accompanies any use of anesthetic agents which are flammable and explosive. With these drugs the hazard may be further increased with high oxygen concentrations. With the proper employment of the carbon dioxide technique and simple preventatives such as proper grounding of equipment and personnel, high humidity and *common sense*, the fire hazard is nil. The explosive hazard is extremely low under the above circumstances. There have been neither fires nor explosions in our two decades of experience with this agent.

Summary

This evaluation of cyclopropane is based on a personal experience with this agent for two decades in three large general hospitals.

Cyclopropane combined with skeletal muscle relaxants is productive of an excellent operative field with a minimum of risk to the patient.

The various types of arrhythmias encountered with cyclopropane are readily reversed by desaturation of the patient. Heart disease is not a contra-indication to its use.

Other complicating factors such as high blood pressure during anesthesia; the increased oozing of blood at the operative site; the post-cyclopropane fall in blood pressure; the sino-aortic and vagal reflexes, and the explosion and fire hazard are discussed and considered not to be serious drawbacks to the use of cyclopropane.

Properly used, cyclopropane continues to be an invaluable inhalation anesthetic agent. It is especially recommended for the poor risk and debilitated patient.

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Thomas Findley Appointed in Augusta

Dr. Thomas Palmer Findley, a distinguished investigator from New Orleans has been appointed to the Georgia Heart Association's Chair of Cardiovascular Research. This appointment brings to the Medical College of Georgia one of the outstanding investigators in the country, a man who

has been head of the section of internal medicine at the famed Ochsner Clinic for twelve years, and who for an equal length of time, has held professional rank on the faculty of Tulane University, School of Medicine, having ascended through Assistant and Associate Professorships.

Present Status of Intravenous Barbituates

A Survey of the Uses of Ultra-Short-Acting Barbiturates



C. R. STEPHEN, M.D.

ANY ATTEMPT TO SUMMARIZE the relevant position of any group of drugs employed today for narcosis inevitably brings into perspective past achievements in anesthesiology. Of these, none is more interesting to contemplate than the quiet daring of Crawford Long as he went about the many duties of a general practice, while at the same time venturing into the unknown world of reversible narcosis. Surely no one man has been more of a stimulus to others who have delved into the mysteries of pain relief. As Dr. Garnett Quillian stated in June, 1921, while dedicating a monument to Long at the University of Georgia: "The measure of true greatness is determined by what one does, the spirit in which one does it, and its usefulness to the world."¹¹

In the last three decades numerous drugs and techniques have been introduced into the sphere of anesthesiology. None of these have supplanted

completely the employment of ether as originally described by Crawford Long, yet several compounds have added refinements which have been welcomed by physician and patient alike. One of the most striking developments has been the progress of intravenous anesthesia, brought to maturity by certain derivatives of barbituric acid.

The story of methods for producing satisfactory anesthesia by the intravenous route reaches back several decades.¹ The search was constantly for "drugs which act promptly, are potent, are rapidly detoxicated and eliminated, have a low degree of toxicity, and have few deleterious side reactions." At the present time, it is felt that evipal sodium, pentothal sodium and surital sodium more nearly fill these demands than any other injectable compounds.

Evipal sodium blazed the trail toward successful intravenous narcosis. Discovered in Germany and first reported clinically in 1932 by Weese and Scharpff,¹² its use became widespread within two years. Its essential chemistry lies in a closed cyclohexenyl ring attached directly to the barbituric ring. In 1934 Lundy⁴ introduced pentothal sodium into clinical anesthesia, and with the years it has come to replace to a large extent its predecessor. Pentothal sodium is a thiobarbiturate with the same chemical formula as pentobarbital sodium, except for one sulphur molecule. Within recent years a third ultra-short-acting barbiturate, surital sodium, has achieved a measure of popularity. This compound is similar to secobarbital sodium, except that again a sulphur molecule has replaced an oxygen molecule. These three drugs are sufficiently alike in pharmacological behavior that their present status may be considered as a group. Minor variations will be discussed as the need arises.

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Methods of Administration

Administration of these drugs may be intermittent, as required by the patient, or more or less continuous as a dilute drip. For the intermittent technique evipal sodium is injected in 5 per cent solution, pentothal sodium in 2.5 per cent solution and surital sodium in 2.0 per cent solution. These concentrations give an approximate idea of the relative potency of these drugs. A continuous drip of 0.05, 0.1 or 0.2 per cent solution is preferred by some administrators who believe that a smoother level of hypnosis may be obtained in this manner.

Accidental extravascular injections of concentrations more potent than those mentioned is liable to produce local tissue irritation and necrosis. Severe pain, sometimes associated with localized ulceration, has been reported with infiltration of a 5 per cent pentothal sodium solution into subcutaneous tissues. Such reactions are rarely noted with the weaker solutions.

Special care should be taken to avoid the injection of ultra-short-acting barbiturates into the arterial system. Aberrant arteries are not uncommon in the area of the wrist and the antecubital fossa. Small amounts (25 to 50 mg.) of these drugs injected intra-arterially will produce intense burning pain in the remainder of the extremity, down to and including the fingers. This is an indication to withdraw the needle immediately. Such administration produces an intense vasospasm of the arterial system in the extremity. Unless prophylactic measures are instituted at once, gangrene of the extremity may occur.⁵ Remedial therapy consists of repeated stellate ganglion blocks, along with the administration of peripheral vasodilating drugs. These steps are aimed at restoring maximal circulation to the injured limb. The possibility of intra-arterial injection can be reduced to a minimum by choosing for injection a vein which is easily accessible on the volar surface of the forearm.

Pharmacological Actions

A) Central Nervous System. Perhaps the most important reason for the widespread "popularity" of the ultra-short-acting barbiturates is the ease with which they produce unconsciousness and hypnosis. It is simple for the anesthetist because he has only to cannulate a vein. The production of unconsciousness in the patient is rarely if ever associated with a feeling of fear or apprehension. This is directly contrary to other groups of drugs which are employed for induction of anesthesia.

The unusual mental feeling of well-being seen with barbiturate administrations is one of their most attractive features for the patient.

Experience has taught that the barbiturates in moderate dosage induce hypnosis primarily, as opposed to analgesia and muscular relaxation which are the two other requirements frequently necessary in general anesthesia. Shortly after their introduction attempts were made to produce all three basic requirements with these drugs alone, but it was soon realized that this could be done only when large amounts of drug were injected. Such large quantities produced deleterious effects on certain organ systems and prolonged considerably the recovery time of the patient. Today these compounds are employed principally for the hypnosis they confer, and other drugs are utilized to induce the required analgesia and muscular relaxation.

B) Respiration. The rapid injection of these drugs produces a direct depressant effect on the respiratory center. Different patients will react in unpredictable manners to similar dosages. Some may remain apneic for as long as five minutes, whereas others will have merely shallow respirations and a diminished tidal exchange. At times when large amounts of a drug have been administered over a period of one or two hours, small increments of 50 to 75 mg. may precipitate apnea for several minutes. Ultra-short-acting barbiturates should never be administered unless there is a means at hand of artificially inflating the lungs of the patient with oxygen. Only in this way can the sudden advent of apnea be treated adequately. The careful anesthesiologist will also have available a laryngoscope and endotracheal tube to establish an unobstructed airway should this be necessary.

C) Cardiovascular System. The rapid administration of moderate doses of the ultra-short-acting barbiturates (400 to 800 mg.) may lead to an abrupt fall in blood pressure. Usually this hypotension persists for only a few minutes and recovery is spontaneous. However, in hypertensive patients and in the older age group recovery may be prolonged and myocardial ischemia is possible. It is believed that these drugs have a direct myocardial depressant effect of some magnitude when injected rapidly.⁷ This effect is less pronounced when the drug is given slowly over a period of several minutes.¹⁰

An alteration of cardiac activity is also observed at times when large quantities (2 to 4 grams) of

drug are injected over an interval of two to three hours. In such instances there may be a progressive narrowing of the pulse pressure associated with an increasing tachycardia. This is believed to be indicative of decreasing cardiac efficiency.⁸ Large doses of these compounds are to be administered with caution.

D) Autonomic Nervous System. Evipal sodium exerts no predominant action on either the sympathetic or parasympathetic outflows. On the other hand, pentothal sodium and surital sodium appear to sensitize the parasympathetic system. It is somewhat paradoxical to think of a depressant drug "sensitizing" a system, so perhaps it might be better to think in terms of these drugs decreasing the activity of the sympathetic more than the parasympathetic. Be that as it may, the injection of the thiobarbiturates tends to increase the hazard of laryngospasm and bronchospasm in patients. When these complications occur, they may prove resistant to treatment. Rarely is the situation alleviated by further administration of the drug. The best single treatment of laryngospasm is the administration of oxygen under positive pressure with an anesthetic bag and face mask. In competent hands the injection of muscle-relaxant compounds along with the oxygen may abort the spasm. It is doubtful if the ultra-short-acting barbiturates should be given to patients suffering from frequent asthmatic attacks of ill-determined origin. Their injection may precipitate an attack which is associated with severe hypoxia.

E) Liver and Kidney Function. There is little evidence to indicate that the ultra-short-acting barbiturates have any deleterious effect per se on the function of either of these organs. They may be administered repeatedly to the same patient with no alteration of liver function studies.

F) Hematopoietic System. The function of the blood-forming organs is not impaired by these compounds. There is a tendency towards dilution of the blood volume during administration.

G) Allergic Phenomena. Almost any drug administered to the human will produce allergic manifestations in a few isolated instances. These have been reported with the ultra-short-acting barbiturates.³ Patients with a history of cutaneous or other manifestations at the time of previous administration should not be exposed to the drug again.

Metabolism

The fate of the rapidly acting barbiturates after their disposition in the blood stream was some-

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what of an enigma for many years. Evidence was forthcoming that the liver was capable of metabolizing these compounds.⁹ Some investigators believed that the reticulo-endothelial system was responsible for the breakdown.⁶ Certainly only small amounts of the drug could be recovered unchanged in the urine. The rapid recovery of the patient after the injection of small quantities led one to believe that metabolism into ineffectual compounds occurred in short order. Yet on this basis it was difficult to explain why patients given one to two grams over a period of an hour or two sometimes slept for long periods after the completion of operation.

Considerable light was shed on this problem as a result of work published in 1952.² Two factors are of particular importance. First, the ultra-short-acting barbiturates have a predilection to concentrate themselves in the fat depots of the body. As much as 70 per cent of the total compound injected may be found in these reservoirs. Secondly, the rate of decline of barbiturate levels in the plasma is only about 15 per cent per hour. In other words, the rate of metabolism is not rapid as was believed previously. When small doses are injected into a patient, equilibrium between fatty tissues and the plasma is reached at sub-hypnotic concentrations, and so the patient awakens rapidly. When relatively large doses are injected, the drug accumulates in the fat depots and is released to the plasma as metabolism proceeds. This tends to explain the prolonged recovery period which may be associated with these drugs. Perhaps "ultra-short-acting" is a misnomer which

is applicable clinically when only small doses are given.

Recovery From Anesthesia

As a rule, emergence from anesthesia is smooth and gradual when one of the rapidly acting barbiturates is a principal drug employed. Nausea or vomiting is uncommon, occurring in about five per cent of patients. Occasionally recovery of consciousness is prolonged for several hours and the explanation for this may be found above. At times the patient may be maniacal during recovery. Such patients are usually husky and muscular, and may have a definite alcoholic history. The injection of small doses of morphine intravenously or subcutaneous doses of apomorphine intramuscularly will control this condition.

From time to time, and particularly after evipal sodium administration, patients will exhibit clonic-like movements which are not unlike shivering. These movements involve the entire body and are precipitated by stimulation of the patient. The rectal temperature and the blood pressure and pulse are within normal values. If the patient is left undisturbed, these movements will cease spontaneously in five or ten minutes in most instances. The etiology of this disturbance is unknown.

A pleasant factor for the patient in the recovery period is the amnesia which usually exists. A patient will appear awake, will have control over his vital reflexes, and is able to respond to questions. Yet during conversation the following day he will have little or no recollection of events in the first several hours of the postoperative period.

Complications of Administration

Most of the difficulties which can be encountered during barbiturate anesthesia have been alluded to previously. They may be summarized as follows:

- 1) Extravascular infiltration
- 2) Intra-arterial injection
- 3) Cumulative action
- 4) Respiratory depression or apnea
- 5) Acute hypotension with rapid administration
- 6) Decreasing cardiac function with large doses
- 7) Laryngospasm and bronchospasm
- 8) Occasional allergic phenomena
- 9) Prolonged recovery period
- 10) Excitement during recovery
- 11) "Shivering" movements during recovery

Indications

The recommended indications for the administration of the ultra-short-acting barbiturates are

legion, but they may be divided into four principal groups.

1) For induction of general anesthesia. It is difficult in this day and age, even in teaching institutions, to deny a patient the pleasantness of an induction with one of these drugs. For many people these drugs have eliminated fear from their associations with the operating room. There are few instances when they cannot be used at least to produce unconsciousness.

2) For maintenance of general anesthesia in association with other drugs. The consensus of opinion now is that the ultra-short-acting barbiturates should not be used alone, except for very short procedures in which potent pain stimuli will not be present. In this way large doses, with their associated complications, are avoided. In this age of "balanced anesthesia," the rapidly acting barbiturates produce hypnosis, while other anesthetic drugs induce analgesia and muscular relaxation.

3) For amnesia and sleep, to complement local, regional and spinal analgesia. Frequently patients are extremely apprehensive about being awake during operations performed under conduction analgesia. Their fears may be obtunded by the administration of an ultra-short-acting barbiturate, either intermittently or as a continuous dilute intravenous drip.

4) For therapy of generalized convulsions. Seizures of any etiology may be controlled rapidly and effectively by the intravenous injection of ultra-short-acting barbiturates. Adequate oxygenation of the patient should be promoted actively at the same time.

Limitations and Contra-Indications

The most inclusive contra-indication to the use of these compounds is an administrator who is unfamiliar with the pharmacology and actions of the drugs. The ease of injection is a great temptation for the uninitiated to "give a short anesthetic." The second all-inclusive deterrent to injection is the absence of a mechanism whereby oxygen may be "pushed" into the lungs of the patient. Whenever an ultra-short-acting barbiturate is given, an oxygen tank with anesthetic bag and mask should be the minimum equipment immediately available.

Other limitations and relative contra-indications may be classified as follows:

1) Full stomach. Of course no general anesthetic should be given if the patient is suspected of having eaten recently. Should vomiting be superimposed on the respiratory depression that accompanies injection of the rapid acting barbitu-

rates, a particularly hazardous situation may be created.

2) Advanced pulmonary disease associated with diminished pulmonary reserve. If a pathological process such as pulmonary emphysema has produced a respiratory cripple who has dyspnea at rest or on exertion, the administration of these barbiturates should be undertaken with extreme caution. Any drug which tends to decrease an already precarious tidal volume has potent limitations.

3) "Constitutional" asthma. The patient who suffers from frequent attacks of bronchial asthma is not a good candidate for these drugs. The predominant parasympathomimetic tendencies associated with administration may precipitate an attack or intensify a dormant bronchoconstriction.

4) Severe liver dysfunction. Although the ultra-short-acting barbiturates apparently do not inhibit liver function themselves, their rate of metabolism may be retarded in the presence of severe liver disease. Therefore the dosage administered in such situations should be minimal.

5) Advanced arteriosclerotic cardiovascular disease. The hypotensive phenomena seen with rapid injection and the myocardial weakening effect seen with large doses preclude the routine employment of these drugs in this group of patients.

6) Extremes of age. In the very young and in the very old the dosage of these drugs must be gauged carefully. Although there is no direct contra-indication to the employment of these drugs in such instances, it should be remembered that "a little bit goes a long way."

7) Obstetrical Anesthesia. The employment of the ultra-short-acting barbiturates during the second stage of labor for delivery should be undertaken only by the expert anesthetist. The risk of respiratory depression in the fetus is considerable if there is more than a five minute delay between the injection of the drug and the delivery of the baby. There must be the utmost cooperation between the obstetrician and the anesthesiologist.

8) Surgery in the Region of the Head and Neck. Even minor surgical procedures in these areas should not be undertaken with barbiturate anesthesia unless a patent airway has been guaranteed by the insertion of an endotracheal tube. The risk of inducing reflex laryngospasm with severe anoxia is too great to warrant "taking a chance."

9) Shock. The injection of rapidly acting barbiturates into patients suffering from shock is fraught with extreme danger. The patient in shock is also partially anesthetized, and it may require only 100 to 200 mg. of one of these drugs to instigate an irreversible process. If these patients require general anesthesia, some other drug, preferably one with reversible control like cyclopropane, is to be desired.

Short-Acting Barbiturates

The status of intravenous barbiturates in anesthesia would be incomplete without reference to the short-acting barbiturates, as exemplified by pentobarbital sodium and secobarbital sodium. These are available for administration in 5 per cent concentration, each cc. containing 50 mg. These drugs have been employed for induction of anesthesia, in conjunction with nitrous oxide and muscle relaxant compounds. Their principal field of usefulness today is in the provision of sedation or light sleep for patients undergoing surgical procedures under local, regional or spinal analgesia. They may be injected in doses of 50 mg. until the desired effect is attained. Maximal action can be expected to last about 45 minutes. A dosage greater than 150 mg. in the average patient is apt to produce some degree of respiratory depression.

The injection of these short-acting drugs produces in the patient a pleasant state of relaxation which may be accompanied by a light sleep. In most instances the patient can be aroused at any time and is oriented as to time and place. This is not necessarily true when the ultra-short-acting barbiturates are used for similar purposes. Rarely do these drugs, used in this manner, have any deleterious effect on the cardiovascular system.

Conclusion

There is no doubt that the ultra-short-acting barbiturates are here to stay in anesthesia. The swing of the pendulum toward exaggerated overusage is abating, and they are finding their rightful place in the armamentarium of anesthetic drugs. It is being realized that their primary action is one of hypnosis, and that analgesia and a degree of relaxation are achieved only by a depth of hypnosis which may prove dangerous for the patient. The ultimate result will be safer anesthesia for more patients.

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Easter Seal Campaign Underway

Georgia's Easter Seal campaign, sponsored annually by the Georgia Society for Crippled Children as part of a nationwide effort to help the handicapped, will open March 18 and extend through Easter Sunday, April 18.

Five Medical Association of Georgia members are serving on a Liaison Advisory Committee for the Georgia Society: H. Walker Jernigan, Atlanta; P. A. Mulherin, Augusta; Ralph W. Fowler, Marietta; J. C. Hughston, Columbus; Ruth Waring, Savannah.

Seal funds will be used three ways:

1. *Research* to develop better means of coping with physical handicaps.
2. *Treatment* given at crippled children's centers established by the Seal Agency throughout the state.
3. *Training* of therapists, doctors and teachers to staff the centers, through scholarships. In addition, funds are used for needed equipment, such as braces, wheelchairs and crutches, and for parental instruction so necessary treatments may be continued in the home.

The 1954 Seal campaign will have special significance for all MAG members, since they are co-operating in the current statewide survey of handicapped children being conducted by Dr. Samuel Wishik, of the University of Pittsburgh Graduate School of Public Health. The survey is sponsored jointly by the Georgia Society for Crippled Children and the Cerebral Palsy Society of Georgia.



Georgia has more than 100,000 handicapped children.

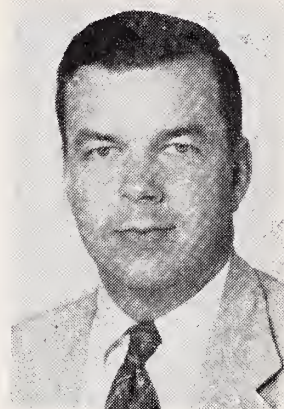
You can give added help by sending an Easter Seal contribution to: Easter Seals, 715 Grand Theatre Bldg., Atlanta—or to your local Seal Chairman.

Modern Balanced Anesthesia

MORE THAN A century now has passed since Crawford Long and his contemporaries introduced both the use of anesthesia into the practice of surgery and the anesthesiologist into the confines of the operating room. In the course of these hundred years, the fundamental *modus operandi* of anesthesia, which is the depression of the activity of the central nervous system and its peripheral aborizations, and the basic aims of the anesthesiologist, which are to alleviate the pain and to obtund the physiological insults resulting from the trauma of surgery, have remained precisely unchanged.

Yet for all that, anesthesiology has undergone, and is presently undergoing, profound alterations. In 1842, anesthesia for the excision of a tumor of the neck was accomplished by the vaporization of ether and the administration of those vapors to the patient. The total armamentarium necessary for the conduct of such an anesthesia consisted of merely a crucible of ether and a home-made inhaler or a piece of lint.

Anesthesia for a similar operation today would consist of a number of agents, several routes of administration, and a variety of different anesthetic techniques. The patient would be premedicated with an oral dose of a barbiturate two hours pre-operatively, and then with a hypodermic injection of both an opiate and a belladonna derivative an hour later. Induction of anesthesia itself would begin with intravenous pentothal administered to the point of hypnosis, when nitrous oxide by the semi-closed inhalation technique would be supplemented to maintain an analgesic state. A succinylcholine infusion would then be begun intravenously, and continued until complete apnea had been achieved, indicating utter muscular relaxation. At this time, the vocal cords and glottis would be exposed by direct laryngoscopy and topical anesthesia produced by means of a 4 per cent cocaine spray. Endotracheal intubation next would be performed by the oral route, to assure a patent airway and adequate oxygenation; and



DAVID M. LITTLE JR., M.D.

Great Lakes, Ill.

the endotracheal catheter would be attached to a non-rebreathing valve to permit the removal of all excessive carbon dioxide. During the maintenance of anesthesia, trichlorethylene would be added to the inhaled mixture to reinforce the analgesia of nitrous oxide. As the operative intervention continued, small, intermittent doses of demerol would be administered intravenously to maintain a sufficient level of basal narcosis until the termination of surgery.

Thus, where Crawford Long used ether alone by the inhalation technique, today a total of nine anesthetic agents and six different techniques would have been employed for the same operation, the excision of a tumor of the neck.

Perhaps this example will be regarded as extreme—and extreme it is—but it serves to illustrate what has come to be called Modern Balanced Anesthesia. Modern Balanced Anesthesia is neither a method nor a technique of anesthesia; rather, it is a philosophy of anesthetic administration. Modern Balanced Anesthesia differs from the ether anesthesia that was conducted by Crawford Long only in the use of several drugs to accomplish adequate conditions for surgery, instead of just one drug alone. The basic aims of the anesthesiologist who employs Modern Balanced Anesthesia are still to alleviate the pain and to obtund the physiological insults resulting from the trauma of surgery, and the means by which these aims are accomplished is still the depression of the activity of the central nervous system and its peripheral aborizations. In order to come to a full and clear understanding of the clinical im-

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port of this philosophy, it will be helpful to consider the evolution of the term Modern Balanced Anesthesia in some detail.

The genesis of this philosophy may probably be said to have been the theory of Anoci-Association, which was proposed by George Crile over forty years ago. Crile, who was impressed by the physiological stresses that operation imposed upon the organism, reasoned that not only must the brain be protected against destructive psychic strain by the use of general anesthesia, but that local anesthetic agents must also be administered in the form of block anesthesia to exclude what he called the noci-impulses, arising at the site of surgical intervention, from reaching the unanesthetized portions of the central nervous system. He was aware that such double protection could be achieved by extremely deep general anesthesia produced with a single anesthetic agent, such as ether or chloroform, but he pointed out that the cost to the patient in terms of deranged metabolism would be too great to be practicable.

Lundy followed a similar line of thought a decade and a half later when he coined the term Balanced Anesthesia, which he defined as the use of a combination of anesthetic agents and methods so balanced that the burdens of the relief of pain would be borne in part by the preliminary medication, in part by regional anesthesia, and in part by light general anesthesia.

The development of such gases as ethylene and cyclopropane, the synthesis of the short-acting barbiturates evipal and pentothal, and the clinical introduction of curare and the other muscle relaxants, led to Combined Anesthesia, the immediate predecessor of Modern Balanced Anesthesia. The method of Combined Anesthesia employs a short-acting hypnotic (pentothal), an analgesic (nitrous oxide, ethylene, or light cyclopropane), and a muscle relaxant (curare itself, or one of its numerous analogues), to produce adequate conditions for surgery without recourse to deep general anesthesia and its attendant physiological disturbances.

The origins of Modern Balanced Anesthesia therefore have concerned themselves with the use of separate agents and techniques for the accomplishment of each of the various purposes of the anesthesia, and the philosophy of Modern Balanced Anesthesia which has grown from these roots has had as its basis the application of these pharmacological principles to the clinical prob-

lem of the administration of anesthesia.

Crawford Long succeeded in abolishing the pain of surgery by depressing the central nervous system with one agent, ether, and the depression of the entire central nervous system was achieved by that single agent. Modern Balanced Anesthesia, on the other hand, uses a number of anesthetic agents, each depressing a particular function or area of the central nervous system. It is, in short, a more precise practice of clinical pharmacology, specific drugs being employed for specific purposes. Where ether alone was utilized previously to produce all the attributes of anesthesia, from unconsciousness to profound muscular relaxation, a number of drugs are now used in combination with one another, each subserving a single aspect of the total anesthesia.

In the example of Modern Balanced Anesthesia presented above, for instance, an oral barbiturate was administered pre-operatively to produce sedation and some degree of basal narcosis; the opiate premedication furthered

A Summary of the Use

this sedation and narcosis, and added, as well, both a sense of euphoria and amnesia; the belladonna derivative effected parasympathetic blockade and dried secretions; pentothal was used to produce hypnosis and unconsciousness; nitrous oxide and trichlorethylene provided analgesia; succinylcholine rendered the muscles utterly flaccid to facilitate endotracheal intubation; cocaine abolished undesirable reflex activity within the larynx during endotracheal intubation; and intravenous demerol maintained a state of basal narcosis to permit the maintenance of surgical anesthesia.

Such exact utilization of drugs for specific purposes during anesthesia has, of course, a tremendous appeal for the scientifically-trained mind; but it is not the scientifically-trained mind that is lying on the operating table with a tumor of the neck which must be excised by surgery. Modern Balanced Anesthesia, however, besides having an intellectual appeal, has the all-important characteristic of offering real and tangible benefit to the patient through the use of safer and less toxic dosages of drugs.

The minimal dose of a drug is the smallest amount which has a therapeutic effect, and the maximal dose is the largest amount which can be tolerated without toxic symptoms. Somewhere between the minimal and maximal doses of a drug lies the optimal, or therapeutic dose. When larger doses of the drug are administered, toxic symptoms supplant or are added to the desirable therapeutic effects; this is the toxic dose. If the dosage of the drug is increased still further, a lethal dosage is achieved, the fatal dose. For all practical purposes, the span between the therapeutic dose and the toxic dose determines the likelihood of toxic effects occurring from the use of a drug, whereas the span between the therapeutic dose and the fatal dose determines the safety of the drug.

It would, of course, be exceedingly convenient if there was a single agent which could perform all the requirements of anesthesia for modern surgery without ever having to be employed in a dosage greater than the therapeutic dose. There is, unfortunately, no such drug. The central nervous system depressants such as ether and the

About the Author

Dr. David M. Little Jr. was born in Boston, Mass., December 1, 1920. He received his A.B. degree from Princeton University and M.D. from Harvard Medical School. His internships were served at Hartford Hospital, Hartford, Conn., and Boston Lying-In Hospital, Boston, Mass. He was resident in Anesthesia at Hartford Hospital, and Exchange resident, McGill Diploma Course in Anesthesiology, Montreal, Canada. He is a diplomate, American Board of Anesthesiology and fellow, American College of Anesthesiologists. He is presently on leave of absence with the armed services from his position as attending anesthesiologist, Grace-New Haven Community Hospital, and Assistant Clinical Professor of Anesthesiology, Yale University School of Medicine, New Haven, Connecticut.

Multiple Drugs in Anesthesia

other hydrocarbon anesthetic agents employed in the past all depress the most highly developed functions of the nervous system first, and the phylogenetically oldest functions last.

The pattern of action of these general anesthetic agents thus consists of an irregularly (in the anatomical sense) paralysis of the central nervous system. These drugs first depress the cortex, then the basal ganglia and cerebellum, and next the spinal cord. First the sensory and then the motor functions of the cord are affected, probably from below upward. Lastly, the medulla is involved, and paralysis of the vital respiratory and vasomotor centers is the usual cause of death from lethal doses.

When ether is employed as the sole agent and the anesthesia progresses from unconsciousness to profound muscular relaxation, the dose of ether necessary to anesthetize each successive area of the central nervous system in this descending paralysis becomes progressively larger, and approaches more closely the lethal dose of ether as a drug. By the time that total

muscular relaxation has been achieved, the entire central nervous system has been paralyzed with the exception of the vital medulla oblongata. At this point, a relatively small additional amount of ether will suffice to paralyze the medulla, and a lethal dose of the drug will have been achieved.

The same can be said of all the drugs used in anesthesia: if employed alone to achieve total anesthesia, they would approach, or in many cases even surpass, their lethal doses. In Modern Balanced Anesthesia, pentothal, for example, effects only hypnosis and unconsciousness. Pentothal is not an analgesic, and it does not provide muscular relaxation: if the agent is administered in a dosage sufficient to accomplish analgesia, the toxic dose is exceeded; and if the drug is further "pushed" to produce muscular relaxation, the lethal dose is approached and barbiturate poisoning is the result. Nitrous oxide, succinylcholine, cocaine, trichlorethylene, demerol, and, indeed, all drugs, may be employed for their specific purposes in therapeutic doses; but when those therapeutic doses are exceeded in an attempt to achieve other effects, the toxic or even the lethal doses of the drugs will be approached, and danger obviously will loom for the patient.

It is the simple problem of using drugs for purposes for which they were not intended. Modern Balanced Anesthesia, by using each drug for a specific purpose, permits total anesthesia for the surgical intervention to be accomplished within the therapeutic dosage of each of these drugs. This means, in essence, safer dosages than would

be possible if only a single drug were employed in a given instance.

Not only is the safety of the patient increased, but the toxicity to the patient is decreased. It has already been noted that when very deep general anesthesia is produced with only one agent, the cost to the patient, in terms of deranged metabolism, is horrendous. The production of anesthesia by the use of several agents, often administered by several different routes, which might then be detoxified and excreted in several different ways, permits adequate anesthesia for the purposes of surgery with far less imbalance of the physiological status quo than would be possible if one drug, which is detoxified and excreted by a single method, were employed alone.

The logic claimed for these combinations of drugs and techniques is the fact that all anesthetic drugs are potentially toxic: if given in excess, as has just been noted, they are quite capable of lethal action; but even if administered skillfully, yet in sufficient dosage to produce true surgical anesthesia, such drugs may precipitate unwarranted alterations in body metabolism.

It is possible, by combining several agents, each being employed in minimal amount, to produce the desired state of anesthesia with the least possible disturbance of physiological function, and

with the smallest possible burden upon each of the different mechanisms of excretion or detoxification. Modern Balanced Anesthesia thus permits the administration of drugs in less toxic doses than would be possible if a single drug were to be employed.

Modern Balanced Anesthesia, therefore, is neither the mere concoction of a complex anesthetic cocktail, nor a heresy against the original agents and simple techniques of the anesthesia practices of an earlier day. It is a philosophy, which has as its goal the application of precise pharmacology during the clinical administration of anesthesia, so that the ultimate result for the patient may be less metabolic imbalance and thus safer anesthesia and surgery. The basic aims of Modern Balanced Anesthesia are the same as those pertaining to anesthesia in the days of Crawford Long: to alleviate the pain and to obtund the physiological insults resulting from the trauma of surgery; and the fundamental *modus operandi* of Modern Balanced Anesthesia is identical with that inherent in the ether anesthesia of a century ago: the depression of the activity of the central nervous system and its peripheral arborizations. It is only the philosophy that has changed—the addition of a little Science to the long-established Art of Anesthesia.

Heart Groups to Meet

The Annual Conventions of the American Heart Association will be held April 1-4, 1954 at the Conrad Hilton Hotel, Chicago, Ill. The Scientific Program of the Section on Clinical Cardiology will be held April 3 to 4 followed by the annual meeting of the American College of Physicians, April 5 through 9, at the same hotel. Reservation blanks for Conventions may be obtained direct or from the Georgia Heart Association, 318 Western Union Bldg., Atlanta, Ga.

The annual meeting and scientific sessions of the Georgia Heart Association will meet September 23-25 at the General Oglethorpe Hotel, Savannah.

The nation's capital will be the scene of a his-

toric world medical gathering next September 12 through 17, when physicians and research scientists from many nations join their United States colleagues in Washington, D. C., for a combined meeting of the Second World Congress of Cardiology and the Twenty-Seventh Scientific Sessions of the American Heart Association. This will be the first international medical gathering of its kind ever held in the United States.

Titles and abstracts of papers from the United States and Canada must be received on or before April 1, 1954, directed to the attention of Dr. Charles D. Marple, Medical Director, American Heart Association, 44 East 23rd Street, New York 10, N. Y.

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			Duodenal	Jejunal	Stomal	Gastric	Good	Fair	Poor	No Report			Complete	Moderate	None	No Report
Grimson, Lyons, Reeves	100	100	93	7			80	11	4		5		47		19	29
Friedman	15	15	14			1	5		4	6 ¹			2			13
Bechgaard, Nielsen, Bang, Gruelund, Tobiassen	26	26	21			5	16	4	6				8	6	12	
McHardy, Browne, Edwards, Marek, Ward	162		162				136	12	11		3	1	14	9	7	129
Segal, Friedman, Watson	34	34	34 ⁴				14	13			7	2	5		8	14
Brown, Collins	117	99	117				97	7	8		5	8	55	9	8	40
Asher	77		65		7	5	52	9	16			16		9	21	47
Rodriguez de la Vega, Reyes Diaz	5	4	5				4		1					3	2	
Winkelstein	116	116	102	8		6	102		14				53		18	45
Hall, Hornisher, Weeks	18	18	18				11		1	6 ¹			18			
Maier, Meili	38	38	24			14 ⁶	27	7	4 ⁷				10	2	5	21
Meyer, Jarman	25	18	25				21		4							25
Poth, Fromm	37	37	37				33	3	1				33	3	1	
Plummer, Burke, Williams	41	41	41				36		5				38		3	
McDonough, O'Neil	104	100	104				63	10	31			11	4		11	89
Broders	60	60	58		1	1	35	19	6				10	1	49 ⁸	
Legerlon, Texter, Ruffin	11		11				11									11
Holoubek, Holoubek, Langford	76	69	76				35	27	10		4	10	26		10	36
Ogborn	42		39	2		1	42 ⁹									42
Shaiken	48	48	48				33	10	3		2		33	10	3	
Johnston	145	145	145				143		2			2	143		2	
Rosell, Knox, Stephenson	146		141			5	146					4 ¹⁰	53			93
TOTALS	1443	968	1380	17	8	38	1142	132	131	12	26	54	552	52	179	634
PERCENTAGES		67.8	95.6	1.2	0.6	2.6	81.3	9.4	9.3			3.7	70.5	6.6	22.9	

1. Not included in tabulations.
2. Included in "Relief of Symptoms" as "Poor" and in "Evidence of Healing" as "None."
3. Four had no symptoms when Banthine therapy was begun.
4. Of which seven were penetrative lesions and five partially obstructive.
5. No symptoms were present in four.

6. Two with symptoms only; no demonstrable ulcer.
7. Three were psychopathic patients and one had a ventricular ulcer of the lesser curvature.
8. Roentgen findings after treatment period of two weeks; forty-seven had duodenal deformity.
9. All returned to work within a week.
10. In these four, after relief of symptoms, Banthine was discontinued because of urinary retention.

During the past three years, more than 250 references to Banthine therapy in peptic ulcer and other parasympathotonic conditions have appeared in medical literature. Of these reports, 22 have presented specific facts and figures on the results of treatment in a total of 1,443 peptic ulcer patients, 67.8 per cent of whom were reported as chronic or resistant to other therapy. These results are tabulated above and show:

"Good" relief of symptoms was obtained in 81.3 per cent of the 1,405 patients on whom reports were available.

"Complete" evidence of healing was obtained in 70.5 per cent of the 783 patients on whom reports were available.

In all but 9.3 per cent, relief of pain was "good" or "fair." In all but 22.9 per cent, evidence of healing was "complete" or "moderate."

During treatment, 26 patients required surgery or developed complications other than ulcer which required discontinuance of the drug before results could be evaluated.

Of the remaining 1,417 patients, only 3.7 per cent experienced side effects sufficiently annoying to require discontinuance of the drug.



*Volume containing complete references, with abstracts of 39 additional reports, will be furnished on request by

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Crawford W. Long: Pharmacist

Extraordinary

WHY DID CRAWFORD W. LONG discover ether for anesthesia? Was he a brilliant young researcher constantly delving into the unknown? How could such an important medical advancement be made in an obscure frontier village in a territory which had been recently occupied by the Cherokee Indians? In spite of the fact that Jefferson, Georgia, was 120 miles from the nearest railroad and in spite of the notoriously poor roads and slow communications, there was no lack of a humanitarian motive or of scientific spirit. It was not, however, the environment which was responsible for Long's discovery of this important property of ether, but his keen mind and close observation of the drugs and chemicals with

lamented his lack of real interest in politics. Long often preferred the company of local druggists to that of his university colleagues. Drug store activity, especially the preparation and compounding of the drugs, constantly whetted his appetite for the scientific. The drug drummers (detail men—medical service representatives) were not too frequent comers to Athens. It was necessary for the local pharmacist to go to the woods and obtain his own crude drugs, and often it was essential that

An Account of the Events that led to the Discovery

which he was so familiar. What was the background of this twenty-six year old youngster who had completed his undergraduate work at the University of Georgia only seven years before? Authentic records are scarce, but let us mix facts and fantasy and draw upon our imagination for the factors which led Dr. Long to his important discovery of ether for anesthesia.

When Crawford W. Long came to Athens to attend the University of Georgia in 1830 at the age of fourteen, he had not made up his mind to study medicine. Indeed, he had little opportunity to even observe medical practice in his home town of Danielsville, some fifteen miles northeast of Athens. The University town of Athens, however, offered a new challenge. There were medical practitioners and apothecary shops (drug stores or pharmacies if you choose to call them that). He enrolled in the University and took the prescribed course consisting mostly of the classics. During his five year stay on the campus he became well acquainted with one of the strongest scientific faculties of that time in the nation. Prominent among these were the LeConte Brothers who were later to become the founders of the University of California.

Long's roommate, Alexander Stephens, destined to become vice president of the Confederacy, marvelled at his companion's scientific interest and

he manufacture his own chemicals. Long could not be considered as working his way through school, but he spent many hours helping in the preparation of the extracts, spirits and elixirs in drug stores in Athens.

This association with pharmacists and local physicians caused Crawford Long to determine to study medicine, but having received his Master of the Arts degree when only twenty years old, he was considered too young by local Athens physicians to start reading medicine. So he returned to his home in Danielsville, where he served as principal of the Academy for a year. This was not to the liking of the young man who had a burning desire to serve humanity. It was a real opportunity when Dr. Grant of Jefferson, Georgia, permitted him to start reading in his practitioner's office. Fortune was kind to James Long, and he could afford to send his son to what was, then considered, one of the best schools of medicine in the



KENNETH L.
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nation—Transylvania University in Lexington, Kentucky. However, at Transylvania, Long apparently became dissatisfied, and it is thought that he missed the opportunity to work and experiment with drugs as was his habit in Athens.

Modern drug history was being made in Philadelphia. Out of this city had come the new second edition of the United States Pharmacopoeia. Long wanted to study medicine, but he also wanted to know more about the medicines he dispensed. So the next year the young Georgian decided to complete his work at the University of Pennsylvania. Here he came under tutorship of that great original thinker, keen observer, and profound scholar—George B. Wood—who taught *materia medica*. Wood, not only edited the United States Dispensatory, but was prominent in the revision of the United States Pharmacopoeia. Dr. Wood insisted that an observer should not be content with one experiment and abhorred the idea of premature reporting of the reactions of drugs. As Dr. Frank Boland has pointed out, Wood's influence on Crawford Long may well have been responsible for his failure to report his experiment in the use of ether for anesthesia.

A group of Georgia boys studying medicine at the University of Pennsylvania boarded at the corner of Market and Nineteenth Streets. It is thought that Long was among this group which experimented with sulfuric ether to experience its exhilarating and soporific effects rather than for any scientific reasons. Nitrous Oxide parties had long been the vogue, but ether was now more convenient. Who is to say that Long did not visualize the use of sulfuric ether as a valuable assistant to entertainment on certain occasions? Long's drug experience may well have led him to believe the product had market value, and perhaps less expensive and at least more novel than alcoholic beverages.

Long completed his medical education at the

University of Pennsylvania in 1839, and went to New York where he spent eighteen months "walking the hospitals". He proved himself an able surgical assistant to some of the leading physicians of the day, learning from such recognized surgeons and teachers of the time as Valentine Mott, Kearney Rogers, and Willard Parker. However, Crawford Long gave up a big city career to return to his native Georgia. Why did he make this decision? Was it because he witnessed great suffering without being able to do anything about it? Did he have the vision that he perhaps could do something about it? Had he already conceived the idea that ether could be used for killing pain, but was afraid his elders would not permit him to experiment? We do know that in a few short months after he left New York and came to Jefferson, Georgia, the discovery was made.

In the quiet pioneer town he reflected on the ether parties of Philadelphia and the suffering of the New York hospitals. The twenty-five year old physician sent to Athens for some ether and, no doubt, had hilarious times with students at the local academy, perhaps encountering some disfavor with the local townspeople and nearby plantation owners. It was during these escapades that the insensitivity to pain, while under the influence of ether, was definitely

About the Author

Dr. Kenneth L. Waters was born in Monroe, Virginia, January 24, 1914. He received his Bachelor of Arts degree from Lynchburg College in 1935, his Master of Science degree from the University of Georgia in 1937, and his Doctor of Philosophy degree in Pharmaceutical Chemistry from the University of Maryland in 1945.

He served as instructor of Chemistry at the University of Georgia from 1937 to 1939 and as a Drug Chemist with the Federal Food and Drug Administration in Baltimore, Maryland from 1939 to 1943. He was engaged in Pharmaceutical Research Work with the Mellon Institute of Industrial Research at Pittsburgh, Pennsylvania from 1943 to 1947. He was Technical Director for Zemmer Pharmaceutical Company of Pittsburgh, Pennsylvania from 1947 to 1948, and has been Dean of the School of Pharmacy, University of Georgia, Athens, Georgia since 1948. Dr. Waters is currently serving as Vice President of the American Association of Colleges of Pharmacy and Secretary-Treasurer of the Southeastern District, National Association of Boards of Pharmacy and American Association of Colleges of Pharmacy.

observed. This fact, coupled with the apparently harmless nature of ether, led to the decision to remove the wen from the neck of James Venable. The story of the first use of ether for anesthesia on March 30, 1842, is so well known that it shall not be repeated here.

Dr. Long's entire career demonstrates his pharmaceutical interest and entitles him to be called "*Pharmacist Extraordinary*". He practiced in Jefferson until 1850 when he moved to the growing town of Atlanta. However, the city practice was not to the liking of the country doctor who was accustomed to preparing and dispensing his own

drugs. Within the next year he moved to Athens. Here, with his younger brother, he established a practice built around his own drug store. There are those who claim that the drug business was Dr. Long's first love. In those days the State of Georgia permitted any licensed physician to also practice pharmacy. The Long drug store was located at what is now known as 247 East Broad Street.

It is interesting to know just what the drug store was like a hundred years ago. So often we hear members of the medical profession and the laity say that the modern drug store sells everything but drugs and cry for the good old days. Contrary to popular opinion, drug stores have not changed as much as one would think. Drs. Long and Long operated what we would consider an ordinary drug store. One of the first advertisements of the Long and Long Drug Store appeared on November 13, 1851, in the Southern Banner and is reproduced for your interest. When one examines this advertisement carefully, its modern counterpart may be seen in almost any daily newspaper. First preference is given to toilet articles and cosmetics, paints, oils, and glass are also given a prominent place. Please note "Have also on hand, a good assortment of Medicines, Drugs, . . ."

The business of Long and Long prospered during the era immediately preceding the War Between the States, and they expanded their interest to become the largest drug wholesale business in Northeast Georgia.

As the clouds of war unfurled, every available man was mustered into the service of the Confederacy. Crawford W. Long, then forty-five years old, remained on the home front, but was not idle. About the only record which can be found on Dr. Long's war service is that, on July 19, 1864, he enlisted as a private, at the age of forty-nine in General Taylor's Infantry. Apparently, he was never called to active duty and remained to serve the community until the close of the war. Long's service to his community did

not go unnoticed. Following the war, in 1867, Surgeon General J. S. Billings of the United States Army appointed him surgeon of the Athens district, a position he held until the civil government was restored.

The people of the Confederacy and its Army were in dire need of drugs. Records are scarce; however, it is known that local pharmacists and physicians were responsible for preparing a list of drugs of native habitat which served as substitutes for the scarce therapeutic items. About a hundred yards from Long's home the remains of a drug garden may be found, the history of which is forgotten. Did Long, among his many other duties, through his drug store, supply at least Northeast Georgia with needed drugs grown locally? It is interesting to note that one of Long's associates in Athens, Dr. LeConte, was named to head a Confederate Laboratory which was established at Columbia, South Carolina.

The duty of this Laboratory was to manufacture ether and other pharmaceuticals as well as to extract and process crude drugs.

Long's interest in various activities was shown when Pharmacist R. M. Smith of Athens attended a convention in Augusta in May, 1863, for the purpose of formation of a Pharmacopoeia of the Confederacy. It is reported that Smith attended at the insistence of Dr. Long who was too occupied with his medical duties to leave the Athens community. Unfortunately,

conditions in the Confederacy at this particular period were not in any way conducive to keeping records and to the functioning of the various committees so necessary to the preparation of a pharmacopoeia. Consequently, "Confederacy Pharmacopoeia" was never published.

In the trying years of reconstruction, professional men in the prostrate South found it difficult to make financial ends meet. Although there was no scarcity of services to be rendered, the populace was unable to pay. During this time, however, the Long Brothers continued to expand their drug interest, although the drug business and

DRS. C. W. & H. R. J. LONG,
HAVE just received from X. BRAZIN, a
choice selection of Toilet and Shaving
Soaps, Cosmetics, Pomades, Extracts for the
Handkerchief, and a variety of Fancy Articles,
—AMONG WHICH ARE—
Jenny Lind, Poucine, Nymph, Amandine and
Honey Toilet Soaps; Philoceme, Eau Lustral,
Jenny Lind, Pomade and Hair Gloss, Beef Mar
row, Bear's Oil, Rose Oil, and Depilatory Pow
der for the Hair.
Perfumes for the Handkerchief, consisting of
extracts of Verbena, Pink, Jessamine, West End,
Lily of the Valley, Jockey Club, Jenny Lind, &c.
Moo-tcha, or Chinese Tooth Paste, Tooth Pow
ders, and Cachori for the mouth.
A large assortment of superior Shaving, Tooth,
Hair and Flesh Brushes.
Have also on hand, a good assortment of Med
icines, Drugs, Paints, Oils, Glass, &c., to which
they respectfully invite the attention of their cus
tomers and the public generally.
Athens, Oct. 23—33—tf.

Advertisement in the Southern Banner, Nov. 13, 1851

ACCIDENT • HOSPITAL • SICKNESS INSURANCE

For Physicians, Surgeons, Dentists Exclusively



\$5,000 accidental death \$25 weekly indemnity, accident and sickness	Quarterly \$8.00	\$15,000 accidental death \$75 weekly indemnity, accident and sickness	Quarterly \$24.00
\$10,000 accidental death \$50 weekly indemnity, accident and sickness	Quarterly \$16.00	\$20,000 accidental death \$100 weekly indemnity, accident and sickness	Quarterly \$32.00

COST HAS NEVER EXCEEDED AMOUNTS SHOWN

HOSPITAL BENEFITS

	Single	Double	Triple	Quadruple
60 days in Hospital.....	5.00 per day	10.00 per day	15.00 per day	20.00 per day
30 days of Nurse at Home.....	5.00 per day	10.00 per day	15.00 per day	20.00 per day
Laboratory Fees in Hospital.....	5.00	10.00	15.00	20.00
Operating Room in Hospital.....	10.00	20.00	30.00	40.00
Anesthetic in Hospital.....	10.00	20.00	30.00	40.00
X-Ray in Hospital.....	10.00	20.00	30.00	40.00
Medicines in Hospital.....	10.00	20.00	30.00	40.00
Ambulance to or from Hospital.....	10.00	20.00	30.00	40.00

COSTS (Quarterly)

Adult	2.50	5.00	7.50	10.00
Child to age 19.....	1.50	3.00	4.50	6.00
Child over age 19.....	2.50	5.00	7.50	10.00

\$4,000,000.00
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PHYSICIANS HEALTH ASSOCIATION

51 years under the same management

\$19,500,000.00
PAID FOR CLAIMS

400 FIRST NATIONAL BANK BUILDING

\$200,000.00 deposited with State of Nebraska for protection of our members

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HILL CREST SANITARIUM

FOR NERVOUS AND MENTAL DISEASES AND ADDICTIONS

Insulin and Electro-Shock Therapy Used in Selected Cases. Gradual Reduction Method Used in the Treatment of the Addictions

Thoroughly modern in architecture and construction. Eight departments—affording proper classification of patients. All outside rooms attractively furnished. Several bathrooms and rooms with private bath on each floor. Also a spacious sun parlor in each department. Located on the crest of Higdon Hill, 1,050 feet above sea level, overlooking the city, and surrounded by an expanse of beautiful woodland. Ample provision made for diversion and helpful occupation. Adequate night and day nursing service maintained. Catalogue sent on request.

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P. O. Box 2896, Woodlawn Station, Birmingham, Alabama

James Keene Ward, M.D., Associate Physician
Phones 9-1151 and 9-1152

"Eh? Oh, I never go!"

says Dr. J. M. Smart, H. & B. D.*

*(Horse and Buggy Doctor)



Don't Be An H. & B. D.

(Horse and Buggy Doctor)

Attend the Annual Session of
The Medical Association of Georgia

May 2-5, Macon, Ga.

Speakers include: Drs. Frank Berry, Ass't. Sec. of Defense; Edward B. D. Neuhouser, Nelson K. Ordway, Edgar Hull, Arthur Colwell, Oscar Creech, Walter B. Martin, Alice McNeal, Franklin L. Payne, Cyrus C. Erickson, Homer Pearson and others.

the pharmaceutical profession was in, what may be described as, a "sad state of affairs". The reason for this poor condition may well be attributed to the Confederacy's attitude toward the conscription of Pharmacists for military service. Realizing the need of pharmacists on the home front to serve the public and especially to supply substitute drugs for the now, non-existent, imported products, the Government had exempted pharmacists from military conscription. The military had called on the local pharmacists to search out native drugs. Unfortunately, for the profession of pharmacy, the existing licensing board for physicians and pharmacists in the state had not concerned itself with enforcing the requirements for licensure for pharmacists. As a result, it was said that there were many good druggists in the state of Georgia, but only a few ever bothered to apply for a license. In this confused state of affairs a number of young men, desirous of dodging the draft, secured a mortar and pestle, a few apothecary jars and crude native drugs and called themselves "druggists". It wasn't until 1875, with the formation of the Georgia Pharmaceutical Association, that this situation began to clear.

From the accompanying advertisement which appeared even before the war, it may be noted that the scientific mind of the discoverer of Ether for Anesthesia although adverse to publicity about his own accomplishments, was in favor of advertisement for items stocked by his drug store. It is with little surprise that we find that Joseph Jacobs, who took his Pharmacy apprenticeship under Dr. Long, gathered ideas concerning sale of merchandise which was to be a new innovation in the drug business. Jacobs soon found that Athens was too small for his dream and moved to Atlanta where he founded his now famous chain of drug stores. It is interesting to note that Jacobs, who was among the early members of the Georgia Pharmaceutical Association, ran into difficulty with the Association when he

started the so-called "cut-rate" drug store and was expelled from the Association, later to be reinstated.

With competent pharmacists to handle the expanded activities of the drug store, Crawford W. Long did not find it necessary to devote much of his time to Pharmaceutical activities; however, his interest in things pharmaceutical never wavered. Although he did not attend the organizational meetings of the Georgia Pharmaceutical Association one can be assured that he offered every encouragement to those in his store, and perhaps Jacobs' interest was spurred on by Dr. Long. It is known that the firm sent its pharmacists over Northeast Georgia to collect crude drugs and processed these for distribution. No doubt other pharmaceuticals were marketed, and who is to say that, except for the adverse economic conditions of the South, Long and Long would have developed into one of the leading pharmaceutical houses in the nation. One of your medical service representatives may well have been detailing pharmaceutical products trade marked "Long and Long" or simply "L and L".

On June 16, 1878, Crawford W. Long suffered a cerebral hemorrhage while in the performance of his medical duties. With his passing, memoranda, records, and his innermost thoughts were never published and were lost to mankind. Had he lived in a different era, or had not his discovery been the subject of such profound controversy, we might have known more of the great man that he was. With records incomplete, we can only mix facts with fantasy and come up with a plausible story of why he was the one to discover ether for anesthesia. This one fact we do know, he was not only a physician, but a "*Pharmacist Extraordinary*". His knowledge of the drug store and his acquaintance with things pharmaceutical, coupled with a brilliant mind, led to one of the greatest benefits that ever befell mankind.

University of Georgia

Influenza 1953 Death Rate

Despite a relatively severe influenza outbreak in January and February, the United States death rate for 1953 remained at the low level of 9.6 per thousand population, according to a preliminary estimate released today by the Public Health

Service of the U. S. Department of Health, Education, and Welfare.

This low rate has been achieved in only two previous years, 1950 and 1952, though the rate has been less than 10 deaths per thousand population since 1948.

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Privine



*for nasal
congestion in
the common cold
or allergy*

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YOU OBSERVE

prompt reduction of turgid mucous membranes.

THE LITERATURE REPORTS

a rapid decongestive effect¹—
“relief lasts for several
hours”²—and a prolonged
reduction of local swelling
and congestion.²

*Supply: 0.05% Solution, 1 oz.
bottle and 15 ml. Nebulizer.*

1. Hild, A. M.: Schweiz. med. Wchnschr.
71:557, 1941.

2. New and Nonofficial Remedies,
J. B. Lippincott Co., Philadelphia, 1953, p. 200

PRIVINE® HYDROCHLORIDE
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Ciba Summit, N. J.

for
“off-season”
allergic
nasal
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Now, as in the pollen season, allergy must be reckoned with as "perhaps the commonest cause of a stuffy nose..."¹ And in "off-season" allergic nasal congestion—as in other allergic manifestations—you can rely on Pyribenzamine for prompt symptomatic relief, with a minimum of sedation or other side effects. Keep this effective prescription in mind whenever you suspect allergy as a factor in "stuffy nose." Pyribenzamine hydrochloride (tripelennamine hydrochloride Ciba) 50-mg. tablets, bottles of 100 and 1000. *For pediatric use*, prescribe palatable Pyribenzamine Elixir; each 4-ml. teaspoonful contains 30 mg. tripelennamine citrate. Pints and gallons.

1. Dill, J. L.: Postgrad. Med. 4:413, 1948.

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No other antihistamine combines greater clinical benefit with greater freedom from side effects

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Ciba products of performance

Apresoline



*for the patient
with moderate
or severe essential
hypertension*

THE PATIENT REPORTS

progressive relief of
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if present.

YOU OBSERVE

benefits in up to 80% of cases:
e.g., hypertension gradually
reduced, renal circulation
improved, eye-ground changes
may be reversed.

THE LITERATURE REPORTS

therapy is generally well
tolerated with initial
low dosages, gradually
increased.^{1,2,3} Patient
response is the guide to
dosage adjustment.⁴ Optimal
maintenance dosage level
is usually reached only
after 3 weeks or more;
marked therapeutic effect
cannot be expected with
initial low dosages.⁴

*Tablets of 10, 25, 50, 100 mg.
Ampuls of 1 ml., 20 mg.*

1. Hafkenschiel, J. H., and Lindauer, M. A.:
Circulation 7: 52, 1953.

2. Schroeder, H. A.: Circulation 5: 28, 1952.

3. Riven, S. S., Pocock, D. G., Kory, R. C.,
Roehm, D. C., Anderson R. S., and
Meneely, G. R.: Am. J. Med. 14: 160, 1953.

4. Taylor, R. D., Dustan, H. P., Corcoran,
A. C., and Page, I. H.: Arch. Int.
Med. 90: 734, 1952.

APRESOLINE® HYDROCHLORIDE
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RECENT STUDY PROVES VALUE OF "TRILENE" INHALATION ANALGESIA

*Safety of self administration
is confirmed in obstetrics*

BROOKLYN, N. Y.—"Trilene" analgesia self administered with the "Duke" University Inhaler, offers an exceptionally high margin of safety for both mother and infant, and provides ease of administration, reported Charles E. Flowers, Jr., M. D., in a paper presented before the Brooklyn Gynecological Society.

In the 602 cases reviewed, no increased tendency to postpartum hemorrhage or other obstetric complication was noted; the incidence of spontaneous breathing in the infants was essentially the same as that of a substantial control group where the mothers received no medication; relief of pain was highly satisfactory; patient cooperation was noteworthy.

These findings are consistent with the published record of effectiveness and safety of "Trilene" inhalation analgesia in obstetrics, as well as in many surgical procedures such as reduction of fractures, removal of painful dressings, incision and drainage of abscesses.

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"Trilene" is nonexplosive, and in the mixtures employed clinically is nonflammable in air and oxygen. "Trilene" may also be used as an analgesic adjunct while light planes of anesthesia are maintained with various anesthetic agents.

"Trilene,"[®] brand of highly purified trichlorethylene (Blue), is supplied in containers of 300 cc.

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Recommended for use with "Trilene" in obstetrics and surgery, the "Duke" University Inhaler is specially designed for economy, facility of handling and ready control of vapor concentration. It can be operated with ease and efficiency by adult or child in the doctor's office, in the hospital, in industrial dispensaries, in the home, or even enroute to the hospital.



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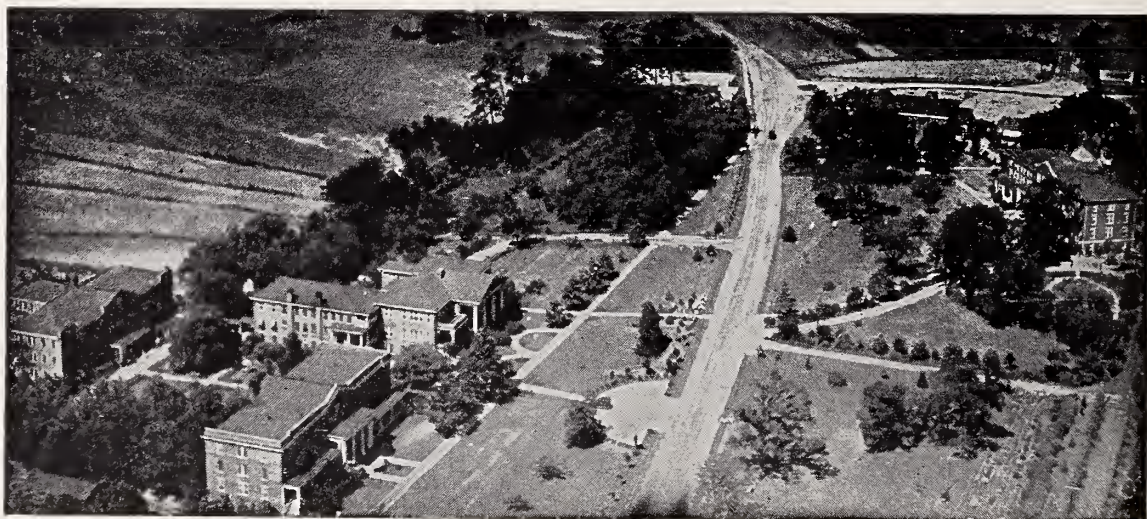
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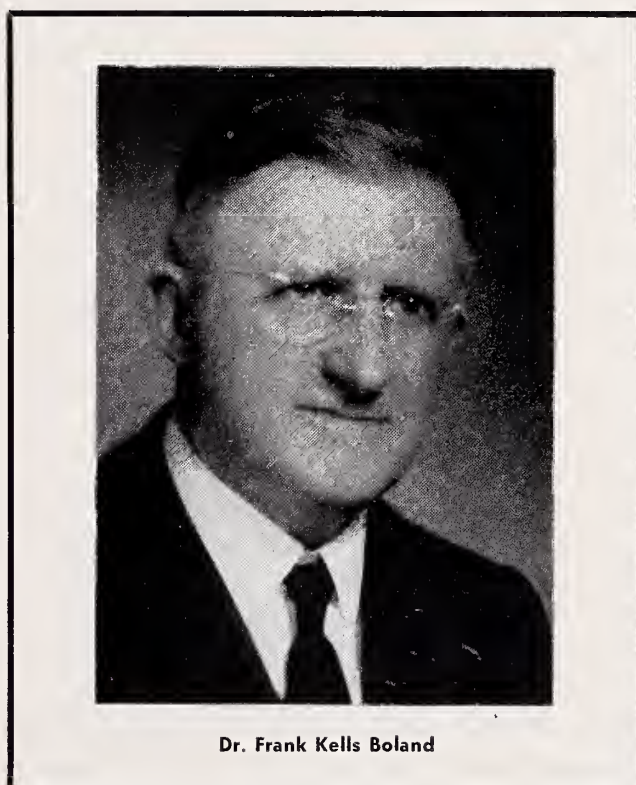
The Late Frank K. Boland's First Published Article on Crawford W. Long

The Discoverer of Anesthesia

WHEN KING EDWARD VII of England, in 1902, awoke from the anesthetic which had been administered to him in performing an operation for perityphlitis, he asked his surgeon, Sir Frederick Trves, "Who discovered anesthesia?" Sir Frederick answered at once, "It was an American, your Majesty, Crawford W. Long."

There are many authorities, however, who will not concede this fact. Osler, a tireless student of medical history, gives another credit for the discovery, as do Welch, Keen, Garrison and others. In discussing the history of anesthesia, the *Encyclopedia Britannica* fails to mention Long's name. We have sat at the feet of these masters and have learned much from them, and we honor them for it. But we also must have respect for the spinster school teacher who taught us arithmetic, and from whom we learned that 1842 is an earlier date in history than 1846. Abundant evidence proves that Crawford W. Long first used ether as an anesthetic in 1842, and William Thomas Green Morton first used it in 1846, four and a half years later.

It affords much pleasure at this time to pay a tribute before the Surgical Section of the Southern Medical Association to the memory of Crawford Long. The gratification at such an opportunity is marred, however, by the fact that such a tribute cannot be paid without reopening old discussions which should have been forever buried. Georgians had hoped the controversy was settled for all time, and not only Georgians, but citizens of all states and of all countries. We do not believe it is a sectional matter, because the supporters of Long are to be found in every part of our country. When a great university saw fit only a few months ago to bestow the laurel upon another brow by placing Morton in its hall of fame as the discoverer of



Dr. Frank Kells Boland

anesthesia, injustice was done, and any tribute to Long must include a vigorous denunciation of the incident.

The regents of this university offered no opportunity to Long's friends to present his claims for this distinction. Long's supporters did not even know that such an important question was to be decided. Such a body of men must have been aware that Morton's claim has always been in dispute. Did they weigh the merits of the two cases? Did they read Marion Sims' judicial statement of the relative claims of Long, Wells, Morton and Jackson in the *Virginia Medical Monthly*, published in May, 1877, or Hugh Young's exhaustive array of arguments and affidavits in the *Johns Hopkins Hospital Bulletin*, published in August, 1897, or Joseph Jacobs' splendid summary of the subject, published in Atlanta in 1919?

It becomes necessary to recite a few well-established facts covering the matter. Crawford W. Long, in Jefferson, Jackson County, Georgia,

Read in Section on Surgery, Southern Medical Association, Fifteenth Annual Meeting, Hot Springs, Ark., Nov. 14-17, 1921. Reprinted from the *Southern Medical Journal*, November, 1922.

removed a tumor from the neck of James M. Venable while he was under the influence of ether without pain to the patient on the 30th day of March, 1842. Horace Wells subjected himself to the effects of nitrous oxid gas and had one of his own teeth extracted without pain to test the value of gas as an anesthetic on December 11, 1844. Charles T. Jackson did not administer ether in any operation, but, it is stated, suggested its use to Dr. William Thomas Green Morton September 30, 1846, and on this date Dr. Morton, a dentist in Boston, extracted a tooth without pain.

If this is the history of the first uses which were made of surgical anesthesia, why has Long not been crowned by all as its discoverer? Dr. Jacobs answers this question in part by calling attention to the fact that the matter has been clouded in doubt, not as to the dates as to the use of ether, but because of the controversy which grew out of the rival claims of Wells and Morton and Jackson before the United States Congress and because of the persistence with which these claimants have urged and repeated their contentions.

The usual arguments of the adherents of William Thomas Green Morton is that, while Long may have been the first to make use of surgical anesthesia, Morton was the first to give it to the world. But did Morton give this wonderful boon to the world? It was not heralded abroad from the use he made of it in September, 1846, in the extraction of a tooth. It was the Boston surgeons, Warren, Bigelow and Haygood, who announced the discovery when they performed an amputation of the thigh, with Morton administering the anesthetic, in the Massachusetts General Hospital, October 16, 1846. Why not give these men the credit for the discovery of anesthesia?

Young Long had no Warren, Bigelow and Haygood to sponsor his discovery and proclaim it to the four corners of the globe, and neither was there a Massachusetts General Hospital in Jefferson, Georgia, or anywhere near it, where anesthesia might be given a test in a major surgical operation. But Long made no secret of his discovery. He talked of it freely to every physician he met. It must be remembered that in 1842 he had been practicing only a year, and as an unknown youth of twenty-seven years he hesitated to give the discovery too wide publicity until he had had opportunity to test it further. Surgical operations came slowly eighty years ago to a young physician practicing in a village of two or three hundred people. The records show, how-

ever, that Long had used ether successfully in five operations before the epochal discovery of Morton was declared to the world by Drs. Warren and Bigelow.

It has been charged that Dr. Long did not appreciate the importance of his discovery, and that he discontinued the use of ether. This is incorrect. The records of a great many of his cases have been lost, but his family preserves enough to show that he employed ether as an anesthetic continually from the time of his discovery until his death in 1878. Ether was used in his obstetrical practice almost as a routine, and he performed many amputations and removed tumors, benign and malignant, under ether.

It is to be regretted that tribute cannot be paid to Crawford Long without reflecting upon Morton, who has been so richly honored, but circumstances will permit of no other kind of treatment. William Thomas Green Morton is hailed as one of the immortals because he was a benefactor of mankind. Was it the part of a benefactor of mankind to patent the beneficial thing, seek to keep its identity a secret and make a great fortune from it? The patent was "letheon," which was ether disguised with aromatic oils. Only the controversy between Morton and Jackson revealed its real nature to the surgeons who were using it. Then this man who has been awarded a place in the Hall of Fame presented a bill in Congress demanding a grant of \$200,000 in recognition of his unselfish services to mankind. The grant was denied, and Morton's priority in the discovery of anesthesia was not recognized. The American Medical Association expressed its disapproval of his conduct in the following resolution, published in its *Transactions*, volume 15, page 53:

"Whereas, In the appropriation bill now pending in Congress is a claim donating to Dr. W. T. G. Morton, of Boston, the sum of \$200,000 as a recognition of his service in introducing sulphuric ether as an anesthetic agent: and,

"Whereas, The said Dr. Morton, by suits brought against charitable medical institutions for an infringement of an alleged patent covering all anesthetic agents, not claiming sulphuric ether only, but the state of anesthesia, however produced, as his invention, has, by this act, put himself beyond the pale of an honorable profession and of true laborers in the cause of science and humanity; therefore,

"Resolved, That the American Medical Association enter their protest against any appropriation to Dr. Morton on the ground of his unworthy conduct; also because of his unwarrantable assumption of a patent right in anesthesia, and further because private beneficence in Boston, New York and Philadelphia has already sufficiently rewarded him for any claim which he may justly urge."

If Dr. Jacobs, that most assiduous student of the life and work of Crawford Long, can succeed in proving another new point upon which he is

COMING

ANESTHESIOLOGY

By DONALD E. HALE, M.D., M.S.

Head Department of Anesthesiology, Cleveland Clinic, Cleveland, Ohio
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now laboring, and which he has good reasons to believe to be true, the advocates of Morton's right to undying fame must be silenced forever. For several years Dr. Jacobs was a young pharmacist in Dr. Long's drug store in Athens, and no living man today is more familiar with the incidents of Long's career. It is well known that in 1854 Charles Jackson visited Long in Athens, Georgia, where he was then practicing, and tried without success to induce Dr. Long to unite with him in laying their claims before Congress as the real discoverers of anesthesia as opposed to Morton. Jackson was then on his way to the gold mines at Dahlonega, Georgia, in which he was interested. Dr. Jacobs believes that this was Jackson's second trip to this part of the country, and that his first visit took place in the period between Long's first use of ether and the announcement of Morton's discovery. In those days in traveling to Dahlonega it was necessary to pass through Jefferson. Dr. Long's operations under ether were being generally discussed at the time and it is very probable that a scientific man like Jackson would have heard the report. If Dr. Jacobs establishes this supposition as a fact, Morton's friends must withdraw another argument which they have maintained, that Morton discovered anesthesia independently of Long, although it was subsequent to Long's achievement. It is admitted by all that Jackson first suggested to Morton the use of ether to cause unconsciousness and insensibility to pain.

Dr. Keen refers to the discovery which Dr. Long "stumbled upon," inferring that the discovery was entirely an accident. Probably many great discoveries are due somewhat to accident, but Dr. Hansell Crenshaw, who devoted much time and thought to Long's work, says that his discovery was due largely first to the fact that he was a close observer; and second, that ever since he served an internship in a New York hospital, where his fine sensibility had been shocked at the pain imposed upon women and children in the operating room, he determined, if possible, to find some means to mitigate such suffering.

Although Crawford Long was born and lived a large part of his life in the backwoods of Georgia, it must not be presumed that he was untutored and uncouth. All the previous training of his life well fitted him for the great discovery which he was to make. Both of his grandfathers were soldiers in the American revolution, emigrated to Madison County, Georgia, and there died, after long lives of usefulness and good citizenship. In this county, at Danielsville, young Long came into

the world November 1, 1815. He received his A.M. degree from the University of Georgia in 1835 and graduated in medicine from the University of Pennsylvania in 1839. It is a remarkable fact that the two citizens of the State of Georgia who have been selected to take their places in the National Hall of Fame at Washington were classmates and roommates at college. These were Crawford W. Long and Alexander H. Stephens, Vice-President of the Confederacy. So far Georgia has not fulfilled her obligation by thus honoring the memory of two of her sons, but the Medical Association of Georgia, principally through the efforts of Dr. Garnett W. Quillian, is endeavoring to have the State erect a monument to the discoverer of anesthesia in its proper place.

Upon leaving the University of Pennsylvania, Dr. Long served an internship in a New York hospital and then practiced medicine in Jefferson, Georgia, from 1841 to 1850. In 1850 he moved to Atlanta, and it is interesting to note that he left this place the next year for the classic city of Athens, because Atlanta was then but a crude village and showed little promise of becoming a city. Long resided in Athens until the day of his death, June 16, 1878, after practicing medicine for nearly forty years.

All who knew him unite in declaring him a man of exceptional qualities of mind and of soul. Dignified in manner, his whole appearance betokened the gentleman. It is said that he possessed no eccentricities, very unusual in a celebrity. He was sensitive, refined and considerate of others; free from envy, malice and all uncharitableness. He maintained a slight reserve, except among intimates and congenial people. Cheerful in the sick room, he inspired his patients with confidence. He was a skillful and successful physician; a man fond of Shakespeare and good music; tall and slender, dressed in conventional black, always with frock coat; in short, a high-bred, scholarly, talented gentleman of the old school. This is the picture of Crawford Long.

The discovery of anesthesia may not interest us keenly at this time when we are so engrossed in the pursuit of other important discoveries. But think where we should be today without anesthesia! Think of the courage required to administer ether for the first time! (And, as Da-Costa remarks, think of the courage of the patient who was the first to be put asleep by it!)

Long has been honored in many ways. In 1878 Marion Sims presented the State of Georgia with a heroic size oil painting to be hung in the State

Capitol. In 1912, the University of Pennsylvania unveiled a medallion to perpetuate the memory of its illustrious alumnus. A few years ago Dr. L. G. Hardman, of Georgia, presented to the town of Jefferson a marble shaft commemorating the deed of its former citizen, while in June of the present year a reduplication of the beautiful medallion exhibited at the University of Pennsylvania was placed on the campus of the University of Georgia by Dr. Joseph Jacobs, an alumnus of the institution.

The action of the University of New York in voting Morton a niche in its hall of fame as the discoverer of anesthesia challenges the supporters of Crawford Long to furnish further evidence of their faith in his right to the honor, and if necessary to unearth more reasons for their belief. There was no Southern Medical Association during Long's lifetime, or he would have been one of its most progressive members, as he was of his State association. Shall we stand idly by and permit this glorious distinction to go to another when we know so well that it belongs to one of our own sons? Such reticence on the part of Long is the cause of his delayed recognition today. Our official journal has already gone on record in the matter, and we owe our thanks to its Editor for his courageous editorial in the November issue entitled "Morton, the Imposter, in the Hall of Fame."

If the members of this Section are convinced that Crawford W. Long is entitled to be called the discoverer of anesthesia, I ask you to adopt a resolution to this effect, and later to ask the Association to pass a similar resolution. Such a resolution would not be proposed did not the advocates of William Thomas Green Morton persist in pushing his claim. If there are still doubting Thomases among us, and you are not prepared to adopt such a resolution, I beg you to ask the President of the Association to appoint a commis-

sion consisting of one member from each state represented in the Association to investigate the merits of all claimants for this honor, and report their findings at the next meeting of the Association.

Even with the adoption of such a resolution there will be work for us to do. In the crowded curricula of our medical colleges little time is left for the study of the fascinating subject of medical history, but let us take time to teach the truth about the discovery of anesthesia. The status of Crawford W. Long as one of the benefactors of humanity has received many reverses since he made his remarkable contribution and the end of them is not in sight today, but finally he will come into his own for all time. The ultimate verdict of history often is delayed much longer than eighty years. When it is announced, however, we are assured that the name of Long will be linked with those of Harvey, Hunter, Jenner, Pasteur and Lister.

NOTE.—Following the reading of this paper, the resolution here indicated was adopted by the Section, and upon reference to the Association was unanimously adopted at its last general session:

Whereas, Unmistakable proofs show that Crawford W. Long used sulphuric ether to produce surgical anesthesia in Jefferson, Ga., on March 30, 1842; and,

Whereas, Undoubted records show that this was the first time in history that ether was ever used for this purpose; and,

Whereas, We are convinced that Dr. Long did everything in his power, with the facilities at hand, to publish his discovery to the world; be it

Resolved, That the Surgical Section of the Southern Medical Association, in session at Hot Springs, Ark., November 16, 1921, declares that Crawford W. Long, and none other, was the discoverer of anesthesia, and is entitled to the credit and honor for an achievement of such inestimable benefit to medicine and to humanity.

Be it resolved further, That the Southern Medical Association in general session is requested to adopt a resolution similar to this one; and that a committee consisting of one member from each state represented in the Southern Medical Association be appointed by the President of the Association to investigate the merits of all claimants to the honor of being the discoverer of anesthesia, giving the matter proper and careful attention, and report at our next annual meeting.

Conference on Cancer Cytology

Dr. Joseph S. Stewart, Chairman of the Third Annual Seminar and Conference on Cancer Cytology to be conducted by the Cancer Institute at Miami, announces that the conference will be held on April 21-24, inclusive.

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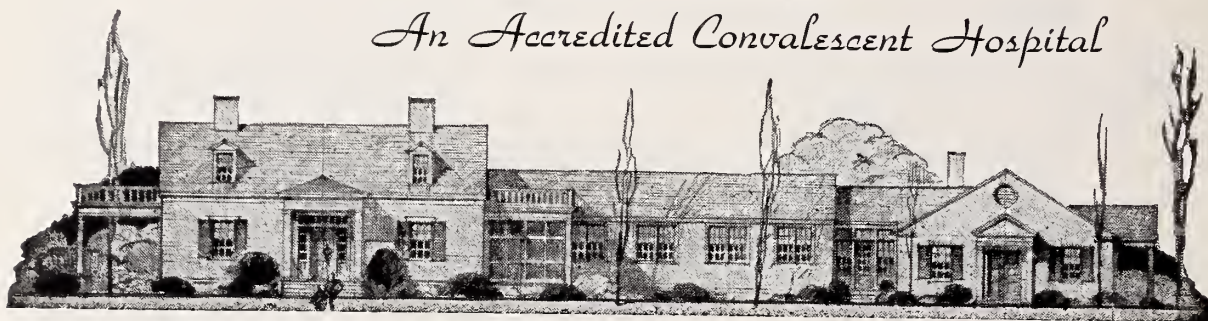
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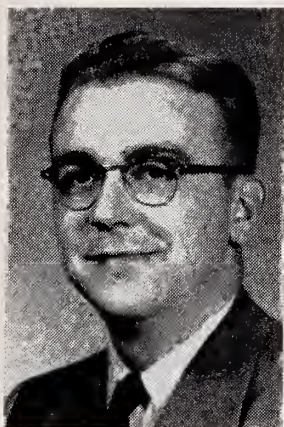
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A Report on Plans for a Memorial to Crawford W. Long



In Memoriam to Pain

LESTER RUMBLE JR., M.D., Atlanta, Ga.

THE LATE DR. Frank Kells Boland devoted much of his lifetime to the gathering of material necessary to prove that Dr. C. W. Long first employed ether for surgical anesthesia. Certainly all doubt has been removed from the controversy. As most of you know, he published a book "The First Anesthetic" in 1950 which set forth the entire story and reproduced all of the documents used to support his claims.

It was during an address in 1950 at Jefferson, Georgia in connection with the publication of his book that Dr. Boland turned to the townspeople and remarked, "Wouldn't it be fitting to establish a memorial museum to Dr. Long, right here in Jefferson—on the site of his office, the spot where ether was first given?"

During this same year the Georgia Historical Commission requested, from every city in the state, suggestions for sites of historical value. Its purpose is to select historical spots and mark them with appropriate memorials.

The response of the citizens of Jefferson was immediate. Within a short time the people of Jackson County, through contributions ranging from fifty cents

to one hundred dollars, had raised their half of the amount necessary to purchase the building now standing on the square at Jefferson. The state then purchased the deed

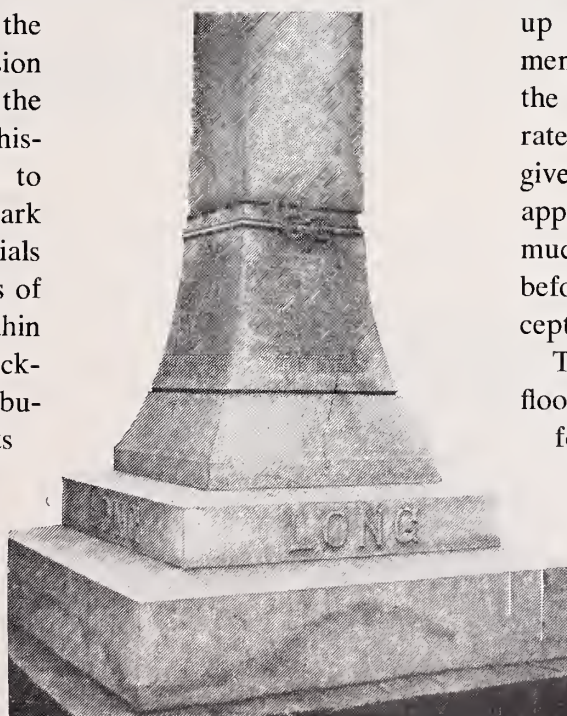
to this property and now holds clear title to the building.

This is not the original office of Dr. Long. It is a brick building, two stories and a basement, on a lot 25 by 60 feet, constructed about 1862, some twenty years after Dr. Long had moved to Athens, Georgia. The basic structure of the building is sound and will serve well to house the proposed museum.

As can be seen in the photographs, two plaques already tell the public that this is the spot, in our state, where the conquest of surgical pain first took place. It seems that a more impressive and thought provoking edifice should be erected.

The Commission is ready to proceed with the museum. Plans have been drawn up to make the museum commensurate with the magnitude of the discovery which it commemorates. The artist's conception gives some idea of its external appearance, and it is obvious that much renovation will be required before the actuality of this conception is achieved.

The building consists of three floors. The basement will be used for office space, rest room facilities, and air conditioning equipment. The main floor plans call for two dioramas (small figurines modeled to scale). One of these scenes will be taken from the photo-





Present Building in Jefferson

graph of the first operation using ether.

The second scene will show the crowd outside the building at the time of this occurrence, and also the arrival of the stagecoach which played such an important role in the controversy over this discovery. Around the walls, it is proposed that a number of tablets be hung. On each tablet is to be inscribed the story of major medical problems which have been conquered.

Vacant tablets will be left on which are to be inscribed the record of the conquest of problems which are still with us. A votive urn will be placed on the first floor, for consideration by those who feel inclined to further medical research in the state of Georgia. No admission fee will be charged, nor will any item be sold on the premises.

Artist's Conception of Proposed Memorial



The second floor will be reached via an outside stairway, in order to lessen construction costs and to avoid encroaching on the available floor space. This floor is to serve as a museum of the progress that has been made in anesthesia since the first use of ether. Where possible, authentic articles will be used. Replicas will be employed where the original cannot be obtained. It is planned that sufficient space may be left vacant to provide for the addition of information about future developments in this field.

The people of Jefferson have worked diligently toward the achievement of this goal, and are willingly cooperating in the further planning that is taking place. The Georgia Historical Commission is ready to begin the construction. All that is necessary is for the Medical Association of Georgia to approve the plans and accept responsibility for the maintenance of this museum when it is completed. A committee has been working out as many of the details as are possible. A report will be rendered at the May meeting in Macon. Your committee would appreciate it if every interested member would read the report and come forward with as many suggestions as possible.

Aside from this being a great tourist attraction, the committee feels the museum will show proper homage to the man who discovered the anesthetic properties of ether. A statue of Dr. Long, carved from Georgia marble by James K. Watt, is in the Statuary Hall of our National Capitol. The Crawford W. Long Memorial Hospital in Atlanta bears his name. There is a life size oil painting in the State Capitol Building, a bronze medallion at the University of Georgia and a statue at Emory University. The United States issued a special postage stamp in 1940 and a granite monument stands on the square at Jefferson, Georgia. Although all of these tributes exist, the proposed museum should rapidly become one of the major historical developments in the South.

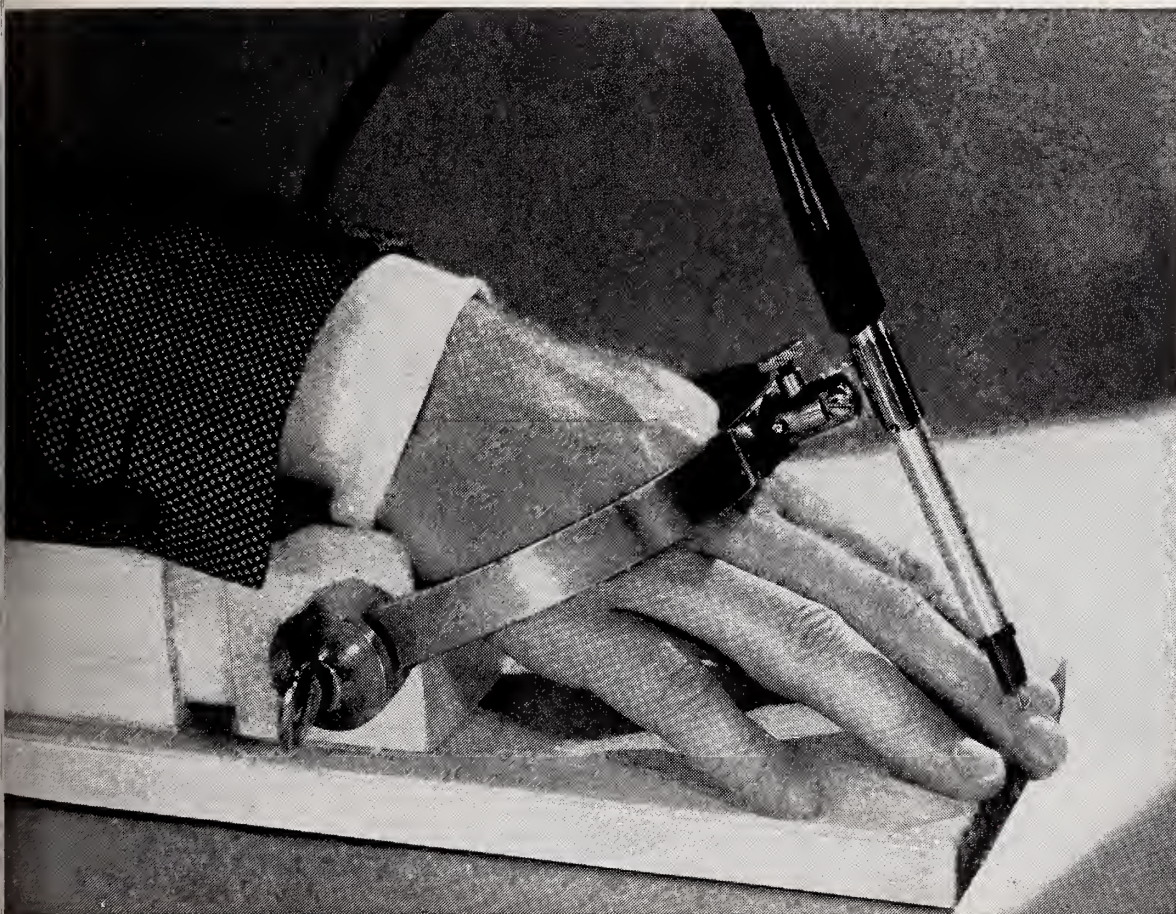
Upon completion of this museum, it is to be turned over to the Medical Association of Georgia. This means that the M.A.G. will have the responsibility of supervision and upkeep. Last year a certain sum was allotted to cover the maintenance of this project. The committee will again request this sum, in order to be certain that we can do *our* part in making this a suitable memorial.

Photos by Ted F. Leigh, M.D.

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Diet and Arteriosclerosis

THAT THE LONGEVITY of our population is increasing is a well-established fact. With an older population, the medical problems presented revolve more and more around arteriosclerosis. Arteriosclerosis may be a completely innocuous finding; but, if strategically placed, as in coronary, cerebral, or renal vessels, the outcome is often catastrophic. Arteriosclerosis is, however, not merely a disease of older age; it is being recognized with increasing frequency in younger age groups. Myocardial infarctions in the thirties are not the rarities they were once considered. There is much factual data extant concerning arteriosclerosis; unfortunately, there is equally as much fancy. As is true of so many unsolved medical problems, there are nearly as many ideas of pathogenesis and therapy as there are physicians interested in the subject. The role of diet in arteriosclerosis has come under intense study in recent years. It is to be emphasized that there is no unanimity of opinion.

The following points are believed to be pertinent to the subject at this time.

1. Arteriosclerosis can no longer be considered just a consequence of the aging process. It represents a disturbance in lipid metabolism. Perhaps it may be preventable and curable. Among conditions known to predispose to arteriosclerosis are myxedema, obesity, diabetes, hypercholesterolemia, and hypertension.

2. Arteriosclerosis has been produced in experimental animals, not naturally affected by the disease, by the feeding of large amounts of cholesterol. For man to remain on a cholesterol free diet, the exclusion of eggs, milk, and many other food items is required; the resulting diet is highly unpalatable. Though there are some conflicting data, the bulk of evidence indicates that the complete avoidance of cholesterol in the diet does not appreciably alter the cholesterol content of the serum unless hypercholesterolemia exists. Ex-

plaining this, no doubt, is the fact that cholesterol can be synthesized from such a simple product of metabolism as acetate.

3. Although still in the experimental stage, there is no convincing evidence to this date that abstinence from cholesterol alters the ravages of arteriosclerosis in the individual so affected.

The picture can be painted a little brighter, however. Remembering that there are certain factors and diseases that predispose to arteriosclerosis, attempts should be made to correct these.

a. Myxedema is to be considered and appropriately handled.

b. Diabetes is to be looked for and properly regulated with diet and/or insulin. Here the hypercholesterolemia will often respond in a gratifying fashion to the regulation of the diabetes.

c. Obesity: There is little question but that obesity shortens life appreciably. This is a long appreciated clinical observation that has had ample confirmation in actuary tables. Furthermore, the complications of arteriosclerosis represent the leading cause of death in the obese. Here, then, is where diet plays its biggest role in arteriosclerosis. A low caloric, low fat reduction diet may offer some hope of halting the relentless progress of arteriosclerosis in the obese.

4. No medications to date have shown any ability to halt or to alter the course of human arteriosclerosis.

5. *Summary:* Arteriosclerosis represents the pathologic change resultant from a metabolic defect concerned with the manner in which the body handles fat. The evidence at hand does not warrant long-term, rigid, dietary restriction of fat and cholesterol as a preventive or as a therapeutic measure. In those entities prone to predispose to this defect, appropriate corrective measures *may* be of avail. At all events, control of obesity is essential, not only for those afflicted with arteriosclerosis, but for all persons as well.

Notes on practical aspects of cardiovascular diseases . . .
a monthly contribution of the Georgia Heart Association.

abstracts by georgia authors



Bennett, I. L., Jr.; Cary, F. H.; Mitchell, G. L., Jr. and Cooper, M. N.: Acute Methyl Alcohol Poisoning: A Review based on experiences in an outbreak of 323 cases. *Medicine* 32:431-463 (Dec.) 1953.

Observations were made on 323 patients who had ingested bootleg whiskey, containing methyl alcohol (35 to 40% by weight) in Atlanta in October, 1951. During the outbreak 41 deaths occurred; 22 victims were dead on arrival at the hospital or before institution of treatment. Because acidosis was a common sequel to ingestion of methanol, plasma bicarbonate determinations were performed initially on each suspected patient. There were 115 patients who were considered acidotic (CO_2 combining power less than 20 milliequivalents).

As previously noted, there were marked variations in an individual response to dosage and in the length of the latent period. The symptoms and physical findings of acute methyl alcohol poisoning are described in detail, the most outstanding being those related to the ocular system.

Massive alkalization is borne out to be the mainstay of treatment and its prompt institution is mandatory. Seven patients died following correction of their acidosis. Household sodium bicarbonate (baking soda) was found safe for intravenous use in such an emergency. Other forms of treatment are discussed. It is suggested that a possible mode of action of methanol or its derivatives is depression of endogenous CO_2 production through interference with enzyme systems controlling aerobic glycolysis.

Chastain, J. B. and Newlin, L. K., Columbus. Practical Points in Pediatric Diagnosis. *GP* 9:61-67 (Jan.) 1954.

This paper calls attention to a few signs and symptoms and to some peculiarities of the newborn, which are important in pediatric diagnosis.

NEWBORN

(1) Fever of 102-104 F. on the second to fifth day suggests transitory fever of the newborn. This condition responds well to fluids, administered orally or parenterally. (2) Hemoglobin up to 27 grams, and W.B.C. up to 30,000 are within normal limits. (3) Constant drooling suggests esophageal atresia. (4) Sudden shock like condition developing during second to fifth day may be due to ruptured liver. (5) Young infants with severe infections may have normal or subnormal temperatures.

G I SYSTEM

(1) Melanin spots on the lips or oral mucosa suggests intestinal polyposis. (2) G I symptoms is the presence of CNS lesions may be caused by peptic ulcer. (3) Multiple respiratory infections and failure to gain weight in first year suggests cystic fibrosis of pancreas.

RESPIRATORY AND CIRCULATORY

(1) Hemoglobin normally drops to 11.4 grams by the age 10-12 weeks with steady rise thereafter. (2) Absence of femoral pulse suggests coarctation of aorta. (3) Persistent hoarseness suggests papilloma of the larynx.

NEUROLOGY

(1) Repeated attacks of purulent meningitis suggest dermal sinuses of scalp or sacral region. (2) Cerebral thrombosis with resultant brain abscess should be considered when determining the etiology of fever occurring in a patient having cyanotic heart disease. (3) The most common cause of encephalitis is the mumps virus. Parotid involvement may be absent.

UROLOGICAL

(1) A thin urinary stream, difficulty in starting urination, and dribbling strongly suggest congenital bladder neck obstruction.

NUTRITIONAL

(1) Pain and tenderness of extremities between the ages of five and eighteen months should immediately suggest scurvy. This is most frequently misdiagnosed as polio.

Finkle, Alex L.; Prince, Charles L. and Scardino, Peter L., 2515 Habersham Street, Savannah, Georgia: On the Incidence of Calcified Uterine Fibroids. *Am. J. Obst. & Gynec.* 67:79-84 (Jan.) 1954.

Of some 6,000 radiological studies of the abdomen performed over a 6-year-period as part of office genito-urinary investigation, 4,000 were of females. In these, only 5 instances of calcified uterine fibroids were encountered. Survey of pertinent literature failed to disclose a specific figure as to incidence of calcified fibromyomata uteri. It appeared worthwhile to cite briefly the case histories and to present photographs of the 5 cases we had uncovered.

The patients were 32, 53, 69, 75 and 80 years of age. Four were white; one was a Negro. Bladder symptoms were prominent in 4 cases; in one, massive hematuria was the presenting complaint. All suffered varying degrees of lower abdominal discomfort, but a case of 25 years' duration had produced the least symptomatic difficulty. No diagnosis was made pre-radiographically, but suspicion of gross intrapelvic pathology indicated further study. In the two youngest patients hysterectomy fully relieved the complaints; in two other women anodynes were effective; and one patient required no treatment.

In general, calcifications within fibromyomas of the uterus appears to be an innocuous phenomenon, *per se*. However, such tumors can exert dramatic pressure effects upon near-by structures.

Kite, J. H.: Pediatrics in General Practice, the Treatment of Flat Feet in Small Children. *Postgraduate Medicine*, 15:75-78 (Jan.) 1954.

In times past little attention has been given to the etiology of flatfeet. It was thought that flatfeet were inherited or just happened. When a careful study is made of the sleeping and sitting habits of the infant, we find certain mechanical factors which could well be the cause of the flatfeet deformity.

The baby sleeps on his stomach, with his legs spread out to the side in a spread-eagle or frog position. Before birth he is floating in amniotic fluid. After birth he is placed on a firm mattress, and wears a new, stiff diaper which is too large for him. This holds his legs in 90 degrees abduction. His flexed knees will rotate his legs laterally 90 degrees. The great toe rests on the mattress and the foot is bent in the metatarsal joint to an abducted or flatfoot position.

Flatfeet can be prevented by correct sleeping and sitting posture. The outward rotation of the legs, as well as the flatfoot deformity, must be corrected. Swung-in shoes are helpful, but the most important part of the treatment is the correct manual stretching of the feet.

Peeples, Wm. J. and Spence, Martha Jane, Muscogee County Dept. of Public Health, Columbus, Georgia. Pulmonary Cavitation Due to Histoplasma Capsulatum. *Am. Rev. of Tub.* 69:111-115 (Jan.) 1954.

The case reported herein is thought to be the first case of clinical histoplasmosis reported from Georgia. Only four cases of histoplasmosis have been previously reported where pulmonary cavitation was demonstrable. The diagnosis can be established only by demonstrating the fungus in a smear, section, or isolation by culture. Pulmonary tuberculosis may exist concurrently, but no evidence of the disease could be found in this case.

It is important that when lesions of the chest are found resembling tuberculosis, and where tubercle bacilli cannot be found, that examination for fungi on fresh specimens of sputum, gastric contents or bronchial washings be instituted. Ample time must be given for the fungus to grow. The case was first discovered by routine chest X-ray in October, 1949, and was thought to be tuberculosis. No tubercle bacilli were ever demonstrated, though laryngeal biopsy was said to show tuberculosis. The patient was hospitalized in Battey Hospital for two months, but left against medical advice. No proof



From where I sit by Joe Marsh

Wish I'd Said That

You know Miss Perkins. Well, she's been driving her own car around our town for a little more than 30 years.

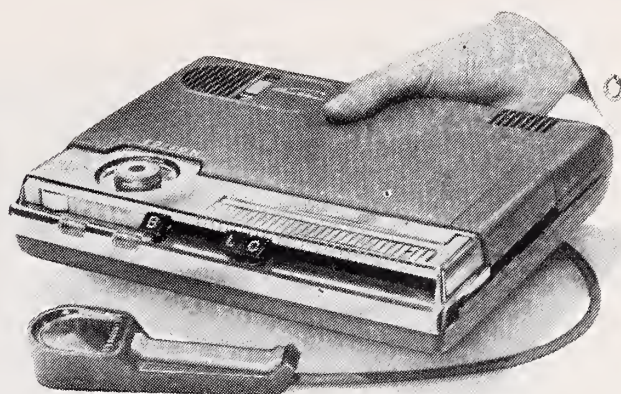
The other day she had a bit of trouble parking down on Main Street. Didn't quite make it the first try, so she pulled out to start over when a fellow waiting to pass started tooting his horn impatiently.

On the second try, she was still having a little difficulty, so this smart aleck behind her hollered, "Lady, do you know how to drive?" "Yes, young man," Miss Perkins answered, "I do. But I don't have time to teach you right now."

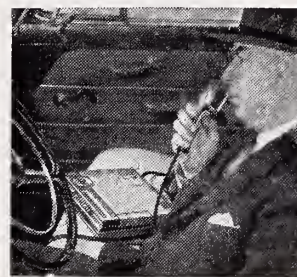
From where I sit, it's not always easy to have a good answer ready just when you need it. But when somebody tells me how to practice my profession, for instance, or to choose tea instead of a temperate glass of beer I like with dinner, I know the answer. We all have a right to our own ideas . . . and none of us like "backseat driving" from anybody.

Joe Marsh

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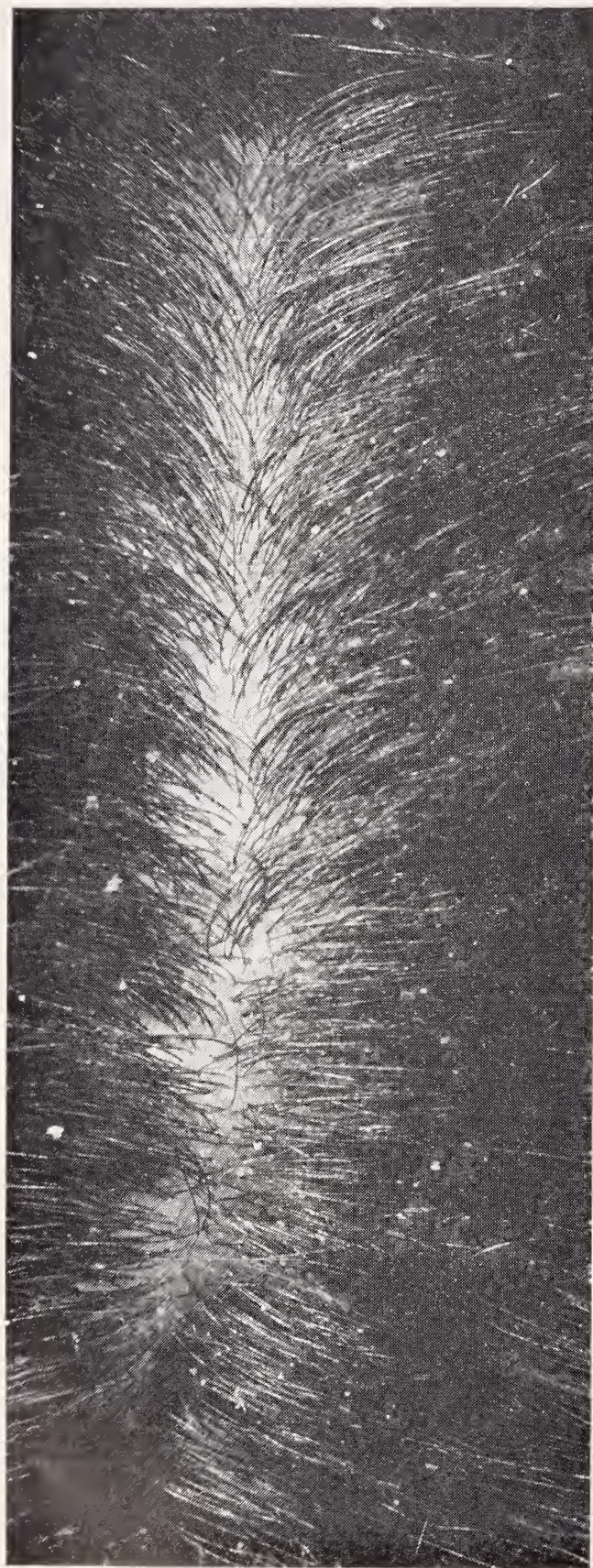
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of tuberculous infection was found and the patient did not improve after six weeks of streptomycin therapy.

Histoplasma capsulatum was isolated from the sputum in August, 1950 and was cultured on three subsequent occasions. Paritized mononuclear cells were seen on direct examination of the sputum. The patient is still alive, and is ambulatory, and though his roentgenogram remains essentially unchanged, much of the infiltration surrounding the cavities has resolved since 1949.

Robinson, W. P. and Moss, B. F., Augusta, Dept. of Psych. & Neur. Medical College of Georgia. Treatment of Bell's Palsy with Cortisone. JAMA 154:142-143 (Jan. 9) 1954.

Though Bell's palsy is a common disorder that may occur in persons of any age from infancy to old age, little or no progress was reported in its treatment until recently. Our use of cortisone in the treatment of two patients who were suffering from the early stage of Bell's palsy was prompted by a report of one such case by Rothendler in 1951.

Case I—A 13-year old girl with paralysis of the right side of face that had persisted for three days. Cortisone as follows: Two 25 mg. tablets t.i.d. for 48 hours; then two 25 mg. tablets b.i.d. for 24 hours. For the next ten days: One 25 mg. tablet t.i.d. Recovery was complete after thirteen days.

Case II—A 5-year old boy with paralysis of the left side of face, which had been present for one week. He was given cortisone in doses somewhat less than those mentioned above. Recovery was complete in seventeen days.

We are encouraged by the results of cortisone therapy in these two patients suffering from the early stages of Bell's palsy. Obviously we cannot draw sweeping conclusions from observations so limited.

Rogers, J. V. and Leigh, T. F.: Differential Diagnosis of right Cardiophrenic Angle Masses, Radiology 61:871-878 (Dec.) 1953.

The authors present sixteen cases with a mass in the right cardiophrenic angle. Six of these were proven to have a pericardial celomic cyst or diverticulum, six had an ommental hernia through the right foramina of Morgagni, and four were due to other causes (lipoma of the thymus, carcionoma of the thymus, mediastinal cyst, and traumatic rupture of the diaphragm).

By radiographic investigation the authors believe it is often possible to identify pericardial celomic cysts, since they usually project into the right major fissure and the small ones frequently have a tear drop configuration in the lateral view. The larger ones do not have this configuration, but may show significant change in shape on respiration.

Omental herniation through the foramen of Morgagni can be identified if there is an associated inverted V appearance of the transverse colon. Or, if a pneumoperitoneum is performed, air will ascend into the hernial sac in the upright position. Only rarely can the etiology of other masses in this

location be established prior to surgical exploration. However, it is possible at times to demonstrate radiographically the structure from which the mass arises.

Williams, G. A.: Arteriovenous Aneurysm of the Uterus. Am. J. of Obstetrics and Gynecology. 67:198-200 (Jan.) 1954.

If it were not such a serious lesion, arteriovenous aneurysm of the uterus could be dismissed as a mere gynecologic curiosity, only three previous cases having been reported. One of the three patients died as a result of hemorrhage at operation, another recovered with residuals of hemiplegia as result of operative complications, and the third was near death from hemorrhage following instrumentation before operation and from postpartum hemorrhage.

The author's patient was fortunate in presenting the classical signs and symptoms and diagnosis of arteriovenous fistula, either in the mediastinum or in the pelvis, was established before operation. The operation was complicated by the coexistence of endometriosis, and troublesome bleeding was controlled with great difficulty. The patient remained well for twelve years and all vascular system phenomena disappeared.

It is strongly recommended that no patient with the signs and symptoms of arteriovenous fistula of the uterus be subjected to dilatation and curettage. If this is considered mandatory, the operating room should be prepared for immediate hysterectomy and adequate replacement of blood should be available.

Woolley, Lawrence F., Atlanta. Occupational Therapy. Am. J. of Psych. 110:530-531 (Jan.) 1954.

It has been plausibly stated and naively accepted in psychoanalytic theory that unconscious fixations frequently determine the choice of occupation. This thesis has not heretofore been critically examined. Opposed to it we have the basic theory of neurosis which postulates that unconscious drives distort conscious actions rather than determine them.

Various unconscious motifs may be partially expressed through work. An incomplete list might include the motifs of feelings of inadequacy; orientations as to object choice in sex relations; fixations as to zonal organization of libidinous drives; aggressive or passivity attitudes; fixations of "part" impulses; non-systematized needs and cravings; etc.

Symbols of sexual motifs occur in various occupational activities: In plumbing, male and female joints, nipples, etc. Straight or long round objects may be used as phallic symbols. "Anything you put something into" may symbolize the yoni. Almost all occupations permit use in discharging anal, oral or other part impulses; aggressive or passive attitudes; auto homo, or hetero-erotic drives; etc. We conclude that choice of occupation in our culture has multiple determinants. It is limited by available occupations and by the capacities of the individual.

Did You Know?

There were 1,984 neonatal deaths in Georgia in the year 1952. Six hundred and three, or nearly one-third of the total neonatal deaths, were immature infants. One infant died out of every 12 born prematurely in Georgia in 1952.

Were these infant deaths always unavoidable? Could some of these 603 premature deliveries have been prevented? Was adequate prenatal care given in every case? Were the factors predisposing to premature labor anticipated and recognized? Were existing facilities adequate for the care of premature infants, and was there prompt and intelligent use of facilities and recognized

measures for the care of premature infants?

Two out of every 100 babies born in Georgia in 1952 died under four weeks of age. Eight out of every 100 born prematurely died less than four weeks old.

Doctor, this is your problem. What can you do to reduce the number of neonatal deaths in Georgia? What can you do especially to prevent the premature delivery of so many babies, and to increase their chances of survival?

*MAG Maternal and Infant
Welfare Committee*

doctor placement page

AVAILABLE PHYSICIANS

Batchelor, Marvin R., M.D., General Hospital, Knoxville, Tenn., age 33, priority 4, married, Methodist, desires general practice in community of 5,000 to 25,000 with well equipped hospital, in Georgia. Graduated University of Tennessee, 1950. Will consider group and industrial practice. Available March, 1954.

Bates, Phillips L., M.D., Quarters "L," U.S. Naval Hospital, Camp LeJeune, N. C., age 35, resigning to inactive reserves, married, Presbyterian, specialty—Urology, desires clinic or as an assistant or associate in community of 30,000 in Georgia, graduate University of Rochester, 1946.

Dwight, J. Brown, M.D., Capt. USAF (MC) 3320th Medical Group, Amarillo AFB, Texas, age 28, at present a physician in the Armed Forces to be released from active duty in January, married, Protestant, graduate Bowman Gray School of Medicine, 1946, completed residency in OB-GYN at the University of Virginia, specialty—Obstetrics and Gynecology.

Dodd, Patricia, M.D. (See Dr. Robert S. McDuffie), age 33, married, desires surgery in community as individual, group or an associate, graduate University of Maryland Medical School, 1944, available April 1, 1954.

Douglas, John J., M.D., 726 14th Ave., Monroe, Wisc., age 38, married, Protestant, desires radiology or an association with doctor in Georgia, graduate University of Rochester School of Medicine.

Gianoulis, James T., M.D., 611 West Grace Street, Richmond 20, Va., age 38, priority 4, married, desires general surgery and gynecology with established surgeon, group or hospital in Georgia, graduate Medical College of Virginia, 1941, six years surgical residency at Medical College of Virginia Hospitals, now available.

Hall, Irving E., Jr., M.D., 8301 16th Street, Silver Springs, Md., age 29, married, Protestant, graduate Cornell University Medical College, 1950, residency at Children's Hospital of D. C., pediatrics, priority 4, interested in pediatrics in Georgia, prefers community of 10,000 to 50,000, available July, 1954.

Hallstrand, David E., M.D., 5 Geisinger Court, Danville, Pa., age 34, priority 4, married, Methodist, desires general surgery in clinic or as an assistant or associate, in Georgia. Graduate Emory University School of Medicine, 1945, graduate University of Pennsylvania School of Medicine, 1950, in surgery, residency at Geisinger Memorial Hospital and Foss Clinic, available July 1, 1954.

Hendrix, Paul C., M.D., 160 South Church Street, Wytheville, Va., served two years in Army with overseas duty, graduate Emory University School of Medicine, 1947, licensed to practice in Georgia, completed 12 months internship and 15 months medical residency at City Hospital, Winston-Salem, N. C., desires general practice in Georgia. Available now.

Hunter, I. H., 204 East Hill Avenue, Valdosta, Ga., age 72, married, Missionary Baptist, graduate Grant University, Tennessee, 1903, specialty pediatrics, prefers community of 1,000, will accept good position with clinic, available April 1, 1954, been in active practice for 50 years.

Ireland, Charles Robert, M.D., Medical College of Georgia, Augusta, Ga., age 34, married, one child, Catholic, graduate Medical College of Georgia, 1950, specialty—Internal medicine, interested in cardiology.

Johnston, J. Howard, M.D., 107 Dauntless Lane, Hartford, Conn., age 36, married, two children, graduate Dartmouth College, 1939, A.B. degree, Long Island College of Medicine, 1943, M.D. degree.

Kaley, J. S., M.D., 887 Myrtle Street, N. E., Atlanta, Ga., age 33, graduate Vanderbilt University, 1946, interested in general surgery in Georgia.

Leigh, Cortland D., M.D., Route No. 1, Box 337, Odessa, Fla., age 38, married, Presbyterian, graduate University of Pittsburgh School of Medicine, 1940, residency in general surgery at St. Luke's Hospital, New York City, and in thoracic surgery at Seton Hospital, in private surgical practice from 1951 to 1953, desires community in need of surgeon or an associate, now available.

Lippett, Devereux, M.D., 125 Elfretth Alley, Philadelphia, Pa., age 29, married, Episcopal, graduate Harvard Medical School, 1947, desires community in Georgia in clinic or as an assistant or associate in pathology and clinical pathology, available July, 1954.

Lipscomb, James W., M.D., 221-C Georgia Tech-Lawson Apartments, Chamblee, Ga., graduate University of Virginia School of Medicine, 1952, residency in internal medicine at the VA Hospital in Atlanta, will be completed by July 1, 1954, desires internal medicine, will consider general practice in community in Georgia, willing to start new practice or to associate in practice already established.

Lyles, William Sloan, M.D., 12 B College Village, Winston-Salem, N. C., age 30, married, Episcopal, graduate Medical College of South Carolina, 1947, 4½ years general surgery, specialty—general surgery, board qualified, prefers private practice, desires community of 5,000 to 60,000, available July 1, 1954.

May, Robert M., M.D., 1908 Rosemary Hills Drive, Apartment 1, Silver Springs, Md., born Camborg, Germany, citizen U. S., married, Hebrew, graduate Louisiana State School of Medicine, 1948, residency at Touro Infirmary, Louisiana, priority 4, specialty Ob-Gyn only, desires community in Georgia, available anytime.

McDuffie, Robert S., M.D., U.S. Naval Hospital, Quarters No. 1219, Quantico, Va., age 34, married, in Navy as reserve medical officer, graduate Emory University School of Medicine, 1944, desires location where he and wife can practice as individual, group or associate, limited to Ob-Gyn, available April 1, 1954. (See Dr. Patricia Dodd).

Merchant, John P., Jr., M.D., P. O. Box 1017, South Miami, Fla., age 28, single, Baptist, graduate Medical College of Alabama, 1952, interested in general practice, prefers community in Georgia, available July 1, 1954.

Mitchell, Helen Krysa, M.D., 25 East Washington Street, Chicago 2, Ill., age 37, married, Catholic, graduate University of Illinois, 1943, residency in dermatology at University of Chicago, specialty—dermatology or public health, desires community of 50,000 in Georgia, available three to six months notice.

Morrow, John G., Jr., M.D., Dept. of Anesthesiology, Presbyterian Hospital, Charlotte, N. C., age 29, married, Methodist, now on active duty, graduate University of Maryland School of Medicine, 1947, residency, Lahey Clinic, Massachusetts, USN Hospital, Maryland, specialty—anesthesiology, desires community in Georgia, available March 15, 1954.

Mozola, Emil W., M.D., 2624 Noble Road, Cleveland Heights 21, Ohio, age 38, married, Catholic, graduate Hahnemann Medical College and Hospital, 1943, priority 4, would like progressive community in Georgia, had considerable experience in orthopedic, urological, gynecological and traumatic, as well as general surgery, interested in private practice where could do fair amount of general work and of major surgery.

Mundy, Charles B., M.D., 202—17 Road, Bayside Queens, N. Y., born New York City, married, Protestant, graduate New York University School of Medicine, 1950, in active duty with U. S. Navy, desires to practice in community of less than 4,000 in Georgia, as general practitioner, available as soon as notified.

Olley, James Francis, M.D., Crawford W. Long Hospital, Atlanta, Ga., age 32, married, Protestant, graduate Jefferson Medical College of Philadelphia, 1945, military service fulfilled, specialty—pathologic anatomy and clinical pathology, clinic or hospital preferred, available July 1, 1954.

Paddock, Robert L., M.D., St. Luke's Methodist Hospital, Cedar Rapids, Iowa, interested in obtaining a location in Georgia suitable for a partnership with Dr. W. D. Regester, available July 1, 1954, general practice, graduate of College of Medical Evangelists in Los Angeles, Calif.

Pittard, M. D., M.D., 1945 Wilford Drive, Brookhaven, Ga., age 27, married, Methodist, graduate Emory University School of Medicine, 1950, at present in the Navy, will be discharged in August, 1954, interested in general practice, clinic, available September 15, 1954.

Porter, Gordon, M.D., 29 Rosebery Place, St. Thomas Ontario, Canada, age 55, married, Canadian, Baptist, graduate Queens University, 1921, residency Chief of Staff—Chief of Surgical Staff, Memorial Hospital, St. Thomas, Ontario, specialty—anesthesia, size of community unimportant, prefers industrial or institutional, now available.

Ranson, Robert F., Captain, MC, Laboratory Service, Rodriguez Army Hospital, Fort Brooke, Puerto Rico, at present in armed forces, graduate University of Oklahoma School of Medicine, 1947, residency in Pathology at same hospital, resident in pathology at Charity Hospital in New Orleans, at Brooke Army Hospital, Sam Houston, Texas, available within six months.

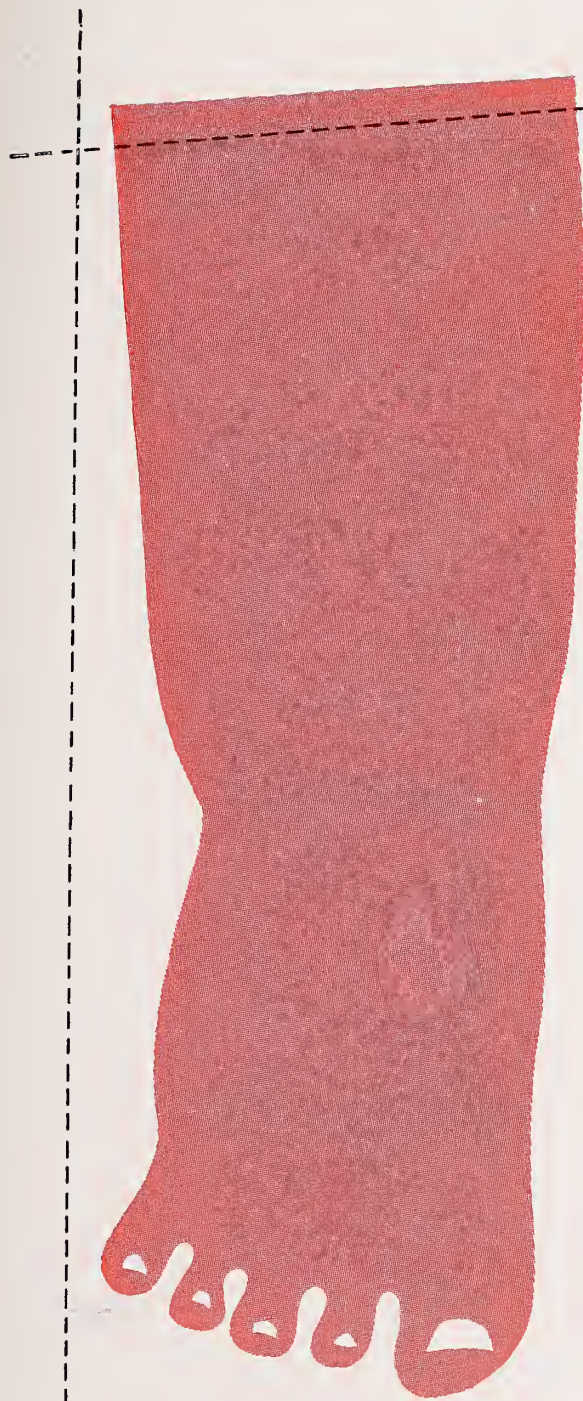
Regester, W. D., M.D., St. Luke's Methodist Hospital, Cedar Rapids, Iowa, interested in obtaining a location suitable for a partnership with Dr. R. L. Paddock, available July 1, 1954, general practice, graduate of College of Medical Evangelists in Los Angeles, Calif.

Rowe, Daniel H., M.D., 418 Purdue Avenue, Orlando, Fla., age 34, married, Presbyterian, graduate Louisiana State University Medical School, 1943, residency Boston City Hospital, at present in air force, specialty Ob-Gyn, desires community in Georgia as an associate or to establish own practice, available April 1, 1954.

Rummel, William David, M.D., 1680 Northwest Boulevard, Columbus, Ohio, age 28, married, graduate Hahnemann Medical College of Philadelphia, 1948, served as general resident at Westmoreland Hospital, Pennsylvania, began ophthalmology residency at Ohio State University in March, 1952, Diplomate of the National Board, desires position as an associate with a Diplomate of the American Board of Ophthalmology, available July, 1954.

Sharpe, Joseph H., M.D., Roswell Park Memorial Hospital, Buffalo, N. Y., born Checotah, Okla., single, Episcopal, graduate University of Oklahoma, 1947, residency at VA Hospital, New Mexico, General Hospital, New York, reserves USN, specialty general surgery, desires community in Georgia, available August 1, 1954.

Sigman, Cheney C., M.D., 1962 Johnson Ferry Road, Apartment 1, Chamblee, Ga., age 26, married, priority 4, Lutheran, specialty—pediatrics, graduate Emory University School of Medicine, 1952, pediatric residency will be completed in July, available July 1, 1954.



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*Stead, E. A., Jr., in Cecil, R. L., and Loeb, R. F.: Textbook of Medicine, ed. 8, Philadelphia, W. B. Saunders Co., 1951, p. 1065.

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1. Malleson, J.: Lancet 2:158 (July 25) 1953. 2. Goldzieher, M. A., and Goldzieher, J. W.: Endocrine Treatment in General Practice, New York, Springer Publishing Company, Inc. 1953, p. 23.

NEW YORK, N. Y.



MONTREAL, CANADA

Stern, Eric, W., M.D., Fairmont Emergency Hospital, Fairmont, W. Va., age 39, born in Vienna, Austria, married, Jewish, graduate University of Vienna, residency Tacoma General Hospital, Washington, Fairmont Emergency Hospital, West Virginia, priority 3, prefers community in Georgia, desires general practice as an associate or part time industrial, available May or June, 1954.

Sturman, Herman G., M.D., 2700 West 15th Place, Chicago 8, Ill., age 27, married, Jewish, graduate University of Illinois, 1950, residency Mt. Sinai, Chicago and Cook County Hospital, Chicago, priority 4, specialty—Ob-Gyn, prefers community in Georgia, desires Ob-Gyn as assistant or associate or clinic, available June, 1954.

Todd, B. Harris, M.D., Philadelphia General Hospital, Blockley Division, 34th Street and Currier Avenue, Philadelphia, Pa., age 30, married, priority 4, graduate Medical College of South Carolina, 1951, residency in medicine to be completed in June, 1954, at Philadelphia Hospital, prefers general practice in small community, available June, 1954.

Tolbert, Louis E., Jr., M.D., Powder Springs, Ga., age 28, married, Presbyterian, graduate University of Tennessee College of Medicine, 1950, priority 4, general practice, available immediately.

Ullmann, Karl H., M.D., 301 Queens Road, Charlotte, N. C., graduate University of Munich School in 1949, is now chief resident in surgery at St. Joseph's Hospital and staff physician at Southwest Tuberculosis Hospital, Tampa, Fla.

Wachtel, Andrew S., M.D., The Hospital U.S. Soldiers' Home, Washington 25, D. C., age 29, married, Baptist, on military duty in Army, graduate Baylor University School of Medicine, 1950, presently completing military tour, desires community in Georgia, industrial or as assistant or associate, available July 1, 1954.

Wornas, Christian G., M.D., 4504 Pine Street, Apartment 107-A, Philadelphia, Pa., age 30, married, Protestant, graduate Marquette University School of Medicine, 1946, specialty—internal medicine, desires community in Georgia, available June, 1954.

AVAILABLE LOCATIONS

Abbeville, South Carolina—Needs general surgeon, two general practitioners, 50 bed hospital, good facilities. Office space available. Housing, schools good. (pop. 5,000). Contact: Mr. Sam A. McAvan, Chairman of Board, Abbeville County Memorial Hospital, Abbeville, South Carolina.

Apalachicola, Florida—Small, well operated county hospital. New modern doctors building for rent, which is well equipped. Doctor-surgeon desired. Contact: G. Cecil Gibbs, Chamber of Commerce, Apalachicola, Florida.

Arlington, Georgia—(Calhoun County) In need of surgeon for practice in the new Terrell County Hospital (28 beds). Contact: Mr. W. B. Bostwick, Arlington City Hospital, Arlington, Georgia. (pop. 1,382).

Attapulgus, Georgia—(Decatur County) Present doctor unable to practice on a full scale, and would like to have another physician to keep up the work. Has clinic with waiting rooms for white and colored patients, x-ray, cardiogram, metabolism, pneumothorax, violet ray, and laboratory equipment. Town is centrally located with access to hospitals. Will reserve working space in the clinic, and will sell outright or lease the clinic at very nominal figure. Will cooperate and assist any doctor coming to this town. (pop. 500) (county pop. 22,234) Attapulgus, Georgia.

Austell, Georgia—(Cobb County) Excellently equipped 16 bed hospital with first rate facilities in nearby Marietta and Atlanta. Contact: Dr. J. G. Bussey, Austell Hospital, Austell, Georgia. (pop. 1,230).

Bainbridge, Georgia—(Decatur County) Office furnished and available now. Need general practitioner. Contact: Dr. Henry A. Bridges, 402 S. West Street, Bainbridge, Georgia. (pop. 7,562).

Broxton, Georgia—(Coffee County) Doctors clinic available, also home. 60 room county hospital at Douglas. 7 room doctors building. Contact: Mr. L. L. Denton, Sr., P. O. Box 198, Broxton, Georgia. (pop. 890).

Cairo, Georgia—(Grady County) Grady County Hospital at Cairo, 31 beds. Suitable office facilities with exam room, etc., available reasonably. Houses available for purchase or rent. Needs two physicians. Contact: Mr. Louis A. Powell, P. O. Drawer 387, Cairo, Georgia. (pop. 9,500).

Clarkston, Georgia—(DeKalb County) Needs general practitioner. Offices available rent free. Contact: Mrs. M. E. Flowers, Clarkston, Georgia. (pop. 1,165).

Conyers, Georgia—(Rockdale County) Hospital clinic now in process of being built between Conyers and Millstead. Office space can be rented reasonably. Houses can be rented or bought. Contact: Mr. O. J. Bradford, Conyers, Georgia. (pop. 2,004).

Crawford, Georgia—(Oglethorpe County) Two hospitals in Athens. Office space available for rent. Housing can be arranged satisfactorily. Contact: Mr. C. A. Townes, Crawford, Georgia. (pop. 10,000).

Dawsonville, Georgia—(Dawson County) Have a modern well equipped health clinic. Arrangements for an office can be made without difficulty. No physician in county. (pop. 500) Contact: Mr. Carlton Gilleland, Mayor City of Dawsonville, Dawsonville, Georgia.

Douglas, Georgia—(Coffee County) New Hill-Burton Hospital (65 Beds) Office space available for rent. Housing can be arranged. Need pediatrician, surgeon, diagnostician. Contact: Dr. T. H. Clark, Douglas, Georgia. (pop. 10,000).

Hampton, Georgia—(Henry County) Hospital in Griffin. Office space, housing available. Contact: Mr. A. L. Cain, Cain's Pharmacy, Hampton, Georgia. (pop. 1,000).

Hawkinsville, Georgia—(Pulaski County) Has a 40-bed hospital. Two suites being built for doctors office. Contact: Mr. W. N. Pate, Chairman, Taylor Memorial Hospital, Hawkinsville, Georgia. (pop. 3,342).

Homerville, Georgia—(Clich County) Offices available without charge. Private hospital. Contact: Mr. E. K. Avriett, Homerville, Georgia. (pop. 1,787).

Lakeland, Georgia—(Lanier County) One hospital in County. Plenty of office space. Housing is available. Doctors to take over operation of new hospital. Contact: Mr. J. B. Powell, Lakeland, Georgia. (pop. 1,502).

Leesburg, Georgia—(Lee County) Office space available, free. Houses for rent reasonable. Home large enough for office. No physician in county. Contact: W. F. Faircloth, Ph.G., Leesburg, Georgia.

Logansville, Georgia—(Walton County) Legion completing a doctors building. Six room houses available. Contact: Dr. Chas. S. Floyd, Logansville, Georgia. (pop. 700).

Lumber City, Georgia—(Telfair County) Nice brick office building. New hospital in same county. Five room and bath office, rent free for two years. Contact: Mr. T. D. Wooten, Wooten Drug Company, Lumber City, Georgia. (pop. 2,500).

Meigs, Georgia—(Thomas County) Available clinic with all facilities. (pop. 927) Contact: Dr. J. N. Isler, Meigs, Georgia.

Midville, Georgia—(Burke County) Has an 8 room clinic. Nice 3 bedroom home. Clear from \$15,000 to \$20,000 annually. Contact: Mr. J. Rife English, Midville, Georgia. (pop. 682).

Newnan, Georgia—(Coweta County) Excellent opportunity for Negro physician. All hospital facilities and privileges granted by white doctors. Modern housing, good schools, churches. Contact: Dr. G. P. Kinnard, Newnan, Georgia. (pop. 8,218).

Newton, Georgia—(Baker County) Hospital in Camilla, 9 miles away. Can rent or purchase an office. Apartments for rent. Contact: Mr. R. F. Mulford, Newton, Georgia. (pop. 503).

Pearson, Georgia—(Atkinson County) Will furnish house, and equip clinic. New Hill-Burton Hospital at Douglas (15 miles) guarantees staff privileges to GP. Office will be rent free for six months. Contact: Mr. Barney Kraft, Pearson, Georgia. (pop. 1,402).

Rockmart, Georgia—(Polk County) Needs two general surgeons, GP. Beautiful Rockmart-Aragon Hospital, 25 beds. Good manufacturing industry. Housing available reasonably. Great need for surgeon. (pop. 4,000). Contact: Dr. J. E. Griffith, Rockmart, Georgia.

Smithville, Georgia—(Lee County) Home in Leesburg, office downtown. Completely equipped office of 2 rooms and connecting lavatory and toilet with outlets for sterilizers, etc., attached. All private practice available. Contact: Mr. Chas. A. Dean, Smithville Drug Store, Smithville, Georgia. (pop. 700).

Snellville, Georgia—(DeKalb County) Office and home under construction, rent free. Community will support doctor. Contact: Mr. Ralph Head, Snellville, Georgia. (pop. 500).

Temple, Georgia—(Carroll County) Office space available. Either rent or purchase home. Two hospitals easily accessible from Temple. Contact: Mr. L. G. Lyell, Temple, Georgia. (Pop. 900).

Tifton, Georgia—(Tift County) Local hospital available. Housing available at reasonable cost. Need GP and EENT. Contact: Mrs. Agnew Andrews, Tifton, Georgia. (pop. 15,000).

Thomson, Georgia—(McDuffie County) Office space in modern building, steam heat, air conditioned. Can supply office furniture if necessary, carpets for floors, etc. Can also supply janitor service. Contact: Mr. G. C. Fite, Knox Building, Thomson, Georgia. (pop. 3,100).

Unidilla, Georgia—(Dooly County) Hospital in county. Office space available or will build small clinic and let doctor rent or buy. Housing will be provided, rent or buy. Guarantee a good doctor will do well. Contact: Mr. E. H. Conner, Unadilla, Georgia. (pop. 1,200).

Warner Robins Air Force Base, Georgia—(Bibb County) Vacancy for a medical officer (occupational medicine) GS-12, \$7,040 per annum. Also for medical officer (general supervisory) GA-13, \$8,360 per annum. Contact: Karl McPherson, Chief, Civilian Personnel Division, Warner Robins, Air Force Base, Warner Robins, Ga.

Warthen, Georgia—(Washington, County) Office space available for rent. Full time physician would have more work than he could do. Contact: Mrs. Macon Warthen, Warthen, Georgia. (pop. 200).

Watkinsville, Georgia—(Oconee County) \$5,000 loan available to doctor interested, free to construct office, rent free. Contact: Mr. Frank E. Stancil, Watkinsville, Georgia. (pop. 800).

Whigham, Georgia—(Grady County) New clinic. Housing available, buy or rent. 52,000 raised for physician to locate in Whigham. Contact: Mr. N. Z. Trulock, Whigham, Georgia. (pop. 700).

Winder, Georgia—(Barrow County) 40-bed hospital recently opened. Office space available for rent. Adequate housing available. Need GP's, surgeon. Contact: Mr. W. C. Harris, Winder, Georgia. (pop. 4,604).

OFFICERS FOR 1953-1954

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Terms Expire December 31, 1955

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C. L. Ayers, Toccoa, Alternate

Terms Expire December 31, 1954

Eustace A. Allen, Atlanta
William R. Dancy, Savannah, Alternate

COUNCILORS

District	Term Expires
1—Lee Howard, Savannah	1955 Session
2—George R. Dillinger, Thomasville	1955 Session
3—W. G. Elliott, Cuthbert	1955 Session
4—J. W. Chambers, LaGrange	1955 Session
5—Mark S. Dougherty, Jr., Atlanta	1956 Session
6—H. Dawson Allen, Jr., Milledgeville	1956 Session
7—D. Lloyd Wood, Dalton	1956 Session
8—Neal F. Yeomans, Waycross	1956 Session
9—W. Bruce Schaefer, Toccoa	1954 Session
10—H. L. Cheves, Union Point	1954 Session

VICE COUNCILORS

District	Term Expires
1—Charles T. Brown, Guyton	1955 Session
2—Carl S. Pittman, Sr., Tifton	1955 Session
3—Guy J. Dillard, Columbus	1955 Session
4—Clarence B. Palmer, Covington	1955 Session
5—J. G. McDaniel, Atlanta	1956 Session
6—H. G. Weaver, Macon	1956 Session
7—Ralph W. Fowler, Marietta	1956 Session
8—James M. Hicks, Brunswick	1955 Session
9—Charles R. Andrews, Jr., Canton	1954 Session
10—J. Victor Roule, Augusta	1954 Session

Report of

MAG Committee on Maternal and Infant Welfare

THE SECOND FULL committee meeting of the Maternal and Infant Welfare Committee of the Medical Association of Georgia was held Sunday, January 17th, from 1:00 to 3:45 p. m., at the Dempsey Hotel, Macon, Georgia, with Peter Hydrick, Chairman, presiding. Other committee members present were: Helen Bellhouse, Secretary; Fred Simonton, Charles Mulherin, and Dr. Howard Morrison. Guests included, Tom McPherson, George Alexander, Maurice Arnold and J. B. Kay.

The following topics were discussed:

MAG Maternal and Infant Welfare Subcommittee—All but nine of the ten district subcommittee members appointed by Dr. Harbin, had indicated, in writing, their willingness to serve.

Their function will be to keep county and district groups informed as to their comparative status in regard to numbers and rates for their respective counties and districts, related to maternal, fetal and infant vital events.

Birth and Death Certificates—The new forms were discussed. Acceptance as a whole had been favorable. Two changes were suggested for clarification to be passed on by secretary to vital statistics (1) "None Known" to be omitted as confusing, or to be clarified to "Normal", "Abnormal" (2) Opportunity be given physicians to clarify degree of prenatal care, i.e. "Adequate," "Inadequate," "None".

Plans for 1954 Annual Session—Exhibit space has been requested and exhibit planned.

(Continued on Page 253)



Nothing Ventured, Nothing Gained

We're not urging you to head for Monte Carlo, or to shoot rapids in a canoe. All we ask is a chance to prove to you that we have a unique Beauty Service. Our cosmetics, selected by a trained Consultant and applied with your newly-educated hand, may be the answer to your dreams . . . All our preparations come to you backed by a ten-day guarantee. "No satisfaction, or else" is our motto. It's not a chance you're taking; it's an opportunity.

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"... reports on its use in patients with pneumococcal pneumonia, surgical infections, or urinary tract infections indicate that the oral administration of tetracycline is followed by rapid clinical response. Symptoms, including fever, largely cleared up within 24 to 48 hours."¹

1. English, A. R.; Pan, S. Y.; McBride, T. J.; Gardocki, J. F.; Van Halsema, G., and Wright, W. A.: *Antibiotics Annual* (1953-1954), New York, Medical Encyclopedia, Inc., 1953, p. 70.

2. Finland, M.: *Brit. M. J.* 2:4846 (Nov. 21) 1953.

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The structure of this *newest* antibiotic represents a nucleus of modern broad-spectrum antibiotic activity.

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This *newest* broad-spectrum antibiotic has a wide range of action against respiratory, gastrointestinal, soft-tissue, urinary and mixed bacterial infections due to pneumococci, streptococci, staphylococci and other gram-positive and gram-negative organisms.

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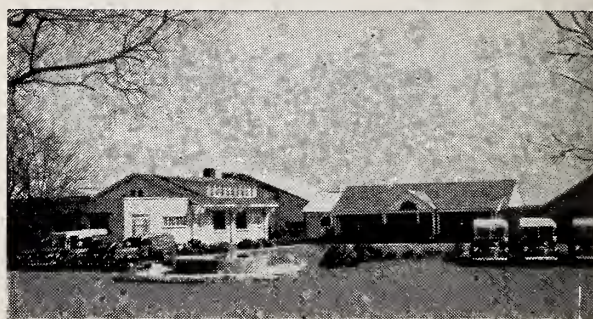
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CERTIFIED MILK stands first in Nutrition. Resistance to disease depends largely on the health of the individual.

Budget for 1954-55—Recommended that funds be requested on 1954-55 budget for one delegate to Tri-State Obstetrics-Pediatrics Seminar at Daytona. The other two states, South Carolina and Georgia, have, in the past been represented by both the MCH Director, and the Medical Association Committee, each of which reports progress. Both Saluda and the Daytona Seminar were recognized as being of great value. A total of \$500 was approved for recommendation to new Council, \$100 for the delegate to Daytona.

Sterilization—A letter from Mr. John Dunaway in regard to the State Eugenic Board, its composition and function was read. A follow through with reference to Council was approved. Dr. Hydrick reported this.

Contraceptives—Dr. Charles Mulherin submitted a report favorable to MAG approval of the use of a product containing P-diisobutylphenoxy-polyethoxyethanol with ricinoleic acid for use in the Public Health Department program, where family spacing was a problem. Referred to Council.

Liaison—Discussion of closer working relationship with other MAG Committees whose program interests overlap, such as the Blood Bank Committee, Hospital Committee and Public Health Committee. The secretary was encouraged to implement this at every opportunity, as were the other Committee members.

Staggered terms of Service for Committee Members—This was considered favorably by the group, as affording continuity and avoiding stag-

nation. Exact terms of office were not stated, but 2, 3, and 4 years seemed to be most favored. Referred to Council for action and advice as to how best to accomplish desired results.

Correspondence—Members to be kept informed of activities before meetings by receiving copies of all correspondence. Will also enable members to function more actively where they are located.

Plan for review of Maternal Deaths—After due consideration the Committee recommends that the "North Carolina Plan" be adopted, since it is a friendly helpful sort of approach and has been effective in North Carolina. (The new fetal death and live birth certificates almost in themselves accomplish the same result for the infants.)

New Physicians and Health Department Materials and Services—Committee recommends to Council that they recommend to State Health Department that as each new physician is registered in the State, he be supplied with material and information about services and requirements, such as the desirability of accurate information on death and birth certificates, particularly since they are now in a form which allows for easy tabulation of information for research, both in public health and private practice.

Vital Statistics—This was discussed and the value of a representative of the Division of Vital Statistics of the Georgia Department of Public Health appearing before senior classes in each university was recognized. In effect, it might make far more accurate and complete reporting. Referred to council.

EDITORIAL (Continued from Page 193)

pigmy blows a curare-tipped dart into his victim before eating him, and the British anaesthetist sticks a curare-filled syringe into his patient before dishing him up to the surgeon. But as more and more unwanted side-effects of the arrow-poison were discovered, and more and more drugs were invented to counteract them, the anaesthetist's syringes grew into a battery of violent poisons and antidotes.

"Today he arrives at the hospital in a van, which contains his assistants and a number of expensive electronic machines to let him know the pulse rate and blood pressure without having to count them. The surgeon is allowed to operate as long as his manipulations do not disturb the anaesthesia: to complain that the narcosis is not sufficiently pro-

found is as unthinkable as sending back the speciality at a famous restaurant. Anaesthetists are friendly men, and have no malignancy in their new mastery: every one of them thoughtfully thanks the surgeon at the end of the operation for making, with his skill, their superb anaesthetic necessary."

I called attention to Mr. Gordon's second sentence with a purpose. Last month we announced through the medium of the *Journal* that an Anesthetic Study Commission is to be proposed in May. It will be the purpose of this Commission to find out whether anesthetists are "becoming less dangerous to human life". Your interest in and cooperation with this Commission is urged.

Lester Rumble Jr., M.D.

SOCIETIES

FULTON COUNTY MEDICAL SOCIETY met February 4, 1954 at the Academy of Medicine. A panel discussion of "Management of Elderly Patients" was presented. Carter Smith served as moderator and panel members were Sterling Claiborne, Duncan Shepard, Major Fowler, Joseph Skobba and William Galvin.

GORDON COUNTY MEDICAL SOCIETY met January 26, 1954 at Myron's Restaurant, Adairsville. Byron Steele, Fairmount, was re-elected president. Other officers named were Bill Purcell, vice president; and Charles Richards, secretary-treasurer.

MUSCOGEE COUNTY MEDICAL SOCIETY met January 26. The members voted to establish a professional relations committee to study patient grievances. Principal speaker was Hughes Kennedy, associate professor of pediatrics at the Medical College of Alabama. New members taken into

the society were Jack W. Hirsch, John Herman Deaton and J. C. Serrato Jr.

OCMULGEE MEDICAL SOCIETY met for the first time in almost two years January 26 at the 341 Restaurant in Eastman. One Hundred percent attendance was recorded. Ed G. Jones, Eastman, was re-elected president and James L. Thomson, Eastman, secretary. W. R. Baker, Hawkinsville, was named vice president. M. F. Arnold, Hawkinsville, was named delegate and D. H. Conner, Eastman, alternate. A grievance committee was appointed consisting of Richard Smith, Cochran; F. P. Holder, Eastman and M. F. Arnold, Hawkinsville. The Society's next meeting will be held in Hawkinsville, April 27.

WARE COUNTY MEDICAL SOCIETY met January 7 with J. Brooks Brown, Jacksonville thoracic surgeon, as speaker and also met February 4 with James King, Atlanta, speaker. Dr. Brown talked on "Cancer of the Lung," and Dr. King's subject was "The Modern Concept of Sinusitis." Both meetings were held at the Okefenokee Golf Club.

PERSONALS

GEORGE H. ALEXANDER, Forsyth, appeared on a television panel program on WMAZ-TV in Macon recently. He talked on the subject of heart disease.

RALPH O. BOWDEN, Savannah, has been re-elected president of the Physicians Service Association of Savannah. Other officers include JOHN ELLIOTT, vice president and MONROE EPTING, C. W. WESTERFIELD, L. B. DUNN, JOHN ZIRKLE, J. H. PINHOLSTER, L. M. FREEDMAN, DAVID PHILLINGIM, G. W. GOLDENSTAR and W. B. CRAWFORD JR., directors.

WILLIAM C. COLES, radiologist, Atlanta, announces the removal of his office to 265 Ivy St., N. E., Atlanta.

JOE D. COMBS, clinical director, Milledgeville State Hospital, was recently certified by the American Board of Psychiatry.

ELLISON R. COOK, Savannah, spoke recently before the Personal Service Club of Savannah on the subject of the need for a rehabilitation center.

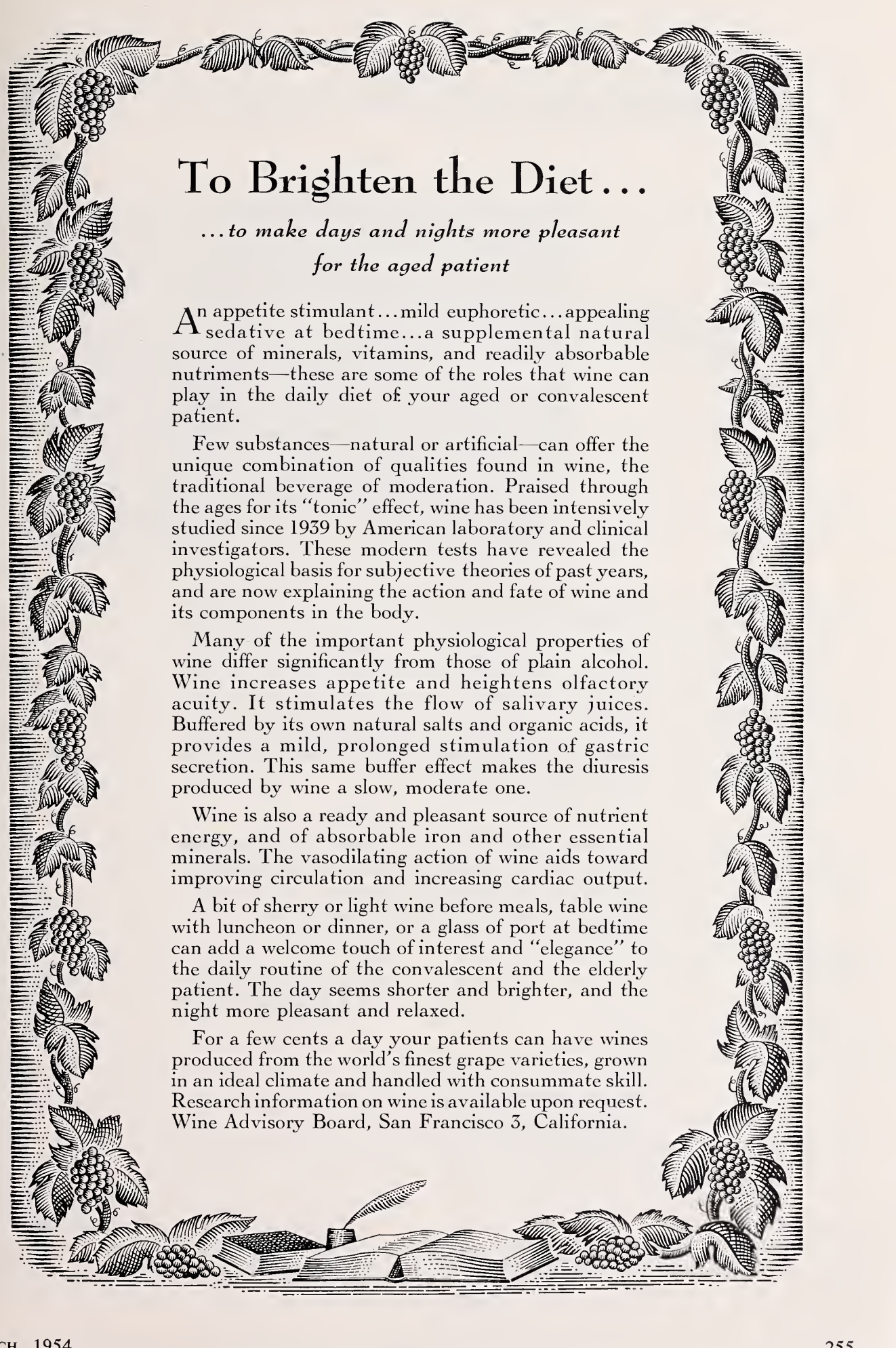
SHELLEY CARTER DAVIS, Atlanta, announces the removal of his office to 909 Doctors Building, Atlanta.

HELEN REED DEAL, Statesboro pediatrician, spoke recently before the Vidalia PTA on the subject "What Do We Want for Our Children?"

E. CARSON DEMMOND, Savannah, was recently re-elected president of the Hospital Service Association of Savannah.

LEILA DENMARK, Atlanta, pediatrician, was recently chosen Atlanta's Woman of the Year for 1953. She and five other leaders in different fields of endeavor were honored at the annual Woman of the Year recognition banquet at the Piedmont Driving Club. Some 600 persons attended.

JOHN A. DUNCAN, Augusta, former head of the medical department for du Pont at the Savannah River Project, has opened offices at 415 Milledge Road for the private practice of medicine.



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Many of the important physiological properties of wine differ significantly from those of plain alcohol. Wine increases appetite and heightens olfactory acuity. It stimulates the flow of salivary juices. Buffered by its own natural salts and organic acids, it provides a mild, prolonged stimulation of gastric secretion. This same buffer effect makes the diuresis produced by wine a slow, moderate one.

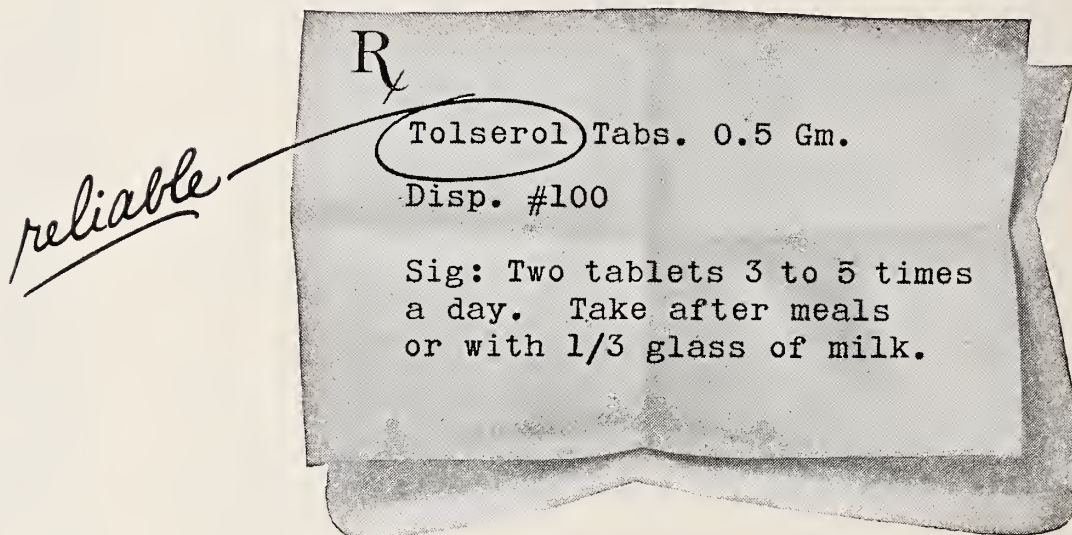
Wine is also a ready and pleasant source of nutrient energy, and of absorbable iron and other essential minerals. The vasodilating action of wine aids toward improving circulation and increasing cardiac output.

A bit of sherry or light wine before meals, table wine with luncheon or dinner, or a glass of port at bedtime can add a welcome touch of interest and “elegance” to the daily routine of the convalescent and the elderly patient. The day seems shorter and brighter, and the night more pleasant and relaxed.

For a few cents a day your patients can have wines produced from the world’s finest grape varieties, grown in an ideal climate and handled with consummate skill. Research information on wine is available upon request. Wine Advisory Board, San Francisco 3, California.



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SQUIBB

Newly elected directors of the Savannah Tumor Clinic, Inc. include ROBERT DRANE, ELLISON R. COOK III, WILLIAM FULMER, C. A. HENDERSON, LEE HOWARD SR., A. J. KELLEY, J. C. METTS, L. M. FRIEDMAN, R. L. OLIVER, S. F. ROSEN, PETER SCARDINO and M. M. SNYDER.

The engagement of E. LEE FRY, Macon, to MISS ELIZABETH ANNE HARRIS was recently announced.

A. V. GAFFORD, Rome, recently addressed the Shorter College Science Club. His topic was "Eye Disease."

DANIEL D. HANKEY, Atlanta, announces the removal of his office to 407 Doctors Building, Atlanta, for the practice of internal medicine.

K. S. HUNT, Griffin, was recently elected president of the Griffin Hospital Care Association.

W. DEVEREAUX JARRATT, Macon, announces the opening of his offices at 626 First Street. He has recently returned to Macon after studying, teaching and practicing at Northwestern University Medical School in Chicago.

H. B. JENKINS, Donalsonville, recently was guest speaker at the Donalsonville Lions Club.

C. V. JOHNSON, East Point, has joined the staff of the LEE M. HAPP JR. Memorial Hospital in Hiawassee. He will be associated with LOUIS P. BRADY in his offices at the hospital.

NELL KENNEY, Dublin, was guest speaker at the dinner meeting of the Business and Professional Women's Club at the Brier Patch, Dublin.

R. RUSKIN KING, Savannah, was recently elected president of the Savannah Obstetrical and Pediatric Society. He succeeds A. J. Kelley. Lawrence Bodziner was elected secretary-treasurer.

The hobby of CLARENCE LAWS, Atlanta—orchid raising—was recently described in an article in the North Side News.

TED F. LEIGH, Atlanta, associate professor of radiology at Emory University School of Medicine, recently described the angiocardigram procedure in an article in *The Atlanta Journal*.

F. R. MANN, *McRae*, was injured recently in an automobile accident on the *McRae-Jacksonville Highway*.

J. M. McELVEEN, Brooklet, recently celebrated his 77th birthday.

R. E. MILLER, Jesup, recently moved his offices to 235-241 Macon Street, Jesup. Also in the same town, R. A. PUMPELLY and FRED HARPER moved their offices in the new Doctor's Hospital on Macon street.

WILLIAM PEEPLES, Columbus, recently addressed the Women's Auxiliary to the Muscogee County Medical Society.

T. A. PETERSON, Savannah, president of the Chatham-Savannah Health Council, recently addressed the Savannah Lions Club and the Savannah Toastmasters Club.

JAMES W. PILCHER, Louisville, was recently praised in an article in the *Atlanta Journal-Constitution* for his work in the community.

MORGAN BURGESS RAIFORD, Atlanta, recently received the degree of doctor of medical science at the midyear convocation of the University of Pennsylvania.

FLOY ROGERS, Coleman, 78-year-old physician who has practiced 57 years in the community recently received a surprise birthday dinner at the Cemochecheobee Clubhouse near Coleman.

CHARLES E. RUSHIN, Atlanta, who was injured in an automobile accident December 4, is recuperating satisfactorily. He returned home from the hospital recently and is now going to his office regularly.

A. W. SIMPSON, J. A. MORROW and W. C. BRANNAN were the principal speakers at a recent meeting of the Washington PTA when a special health program was presented.

CHARLES K. SINGLETON, Elberton, announces the opening of his offices in the Wight Building, Cairo.

GEORGE B. SMITH, Rome, was recently elected chairman of the board of directors of the National City Bank.

R. F. SPANJER, Cedartown, presented state health officials at the recent open house ceremonies for the Polk County Health Center at Cedartown.

C. W. STRICKLER, JR., Atlanta, announces the removal of his office to the Boland Building, 101 Third St., N. E., for the practice of internal medicine.

W. GRANVILLE TABB JR., Atlanta, announces the removal of his offices to the W. W. Orr Doctors Building for the practice of ophthalmology.

H. A. THORNTON, Greensboro, has opened temporary offices in the J. H. McCommons Building next to the Post Office, Greensboro.

I. A. THRASH, Greenville, is recuperating following an operation in city hospital in Columbus.

HOKE WAMMOCK, Augusta, recently addressed the St. Simons Rotary Club on the subject of Cancer Research.

M. E. WINCHESTER, Brunswick, was recently named "Progressive Citizen of the Year. He is

Glynn County health commissioner and hospital administrator.

LUTHER H. WOLFF, Columbus, was re-elected president of Blue Shield Physicians Service, Inc. of Columbus. Other officers named were H. HILT HAMMETT JR., LaGrange, vice president; and GEORGE D. SCHUESSLER, Columbus, secretary-treasurer.

JOSEPH R. YAMPOLSKY, associate professor of pediatrics, Emory University School of Medicine, recently spoke before the Morningside School PTA on the subject "Immunity in Children."

An article in the *Macon Telegraph* recently lauded J. D. ZACHRY, Gray, for his 43 years of practice in the community.

DEATHS

GOODWIN: Henry J., Jr., 44, Douglas, died January 27, 1954 at his home on West Ward Street, Douglas. A native of Coffee County, he received his M.D. degree at the Medical College of Georgia in 1934. He served as intern at the Macon City Hospital and had practiced for 18 years in Douglas.

GOOLSBY: Robert Cullen, Sr., 91, Forsyth, died February 3 in a Macon Hospital. A native of Jasper County, he practiced in Juliette for 15 years before moving his offices to Forsyth some 50 years ago. A graduate of the University of Louisville, Louisville, Ky., he was a member of the Methodist Church and a Mason.

HOGUE: W. L., 74, Villa Rica, died January 19 in the Villa Rica Hospital. He originally prac-

ticed medicine in Draketown but moved to Villa Rica approximately 25 years ago. He was the father of Leroy Hogue, general manager of the Southeastern Motor Lines of Carrollton.

PITTMAN: James Lee, 52, Atlanta, died January 21, 1954, at his home, 2966 Howell Mill Rd., N. W., Atlanta. He had practiced urology in Atlanta for 25 years and had been on the Emory Medical School Staff since 1929. He was president of the Georgia Urological Society at the time of his death and the author of many papers on urology. He was a member of the Southeastern branch of the American Urological Society, the American Board of Urology, the American Urological Assn., the Southeastern Surgical Congress, the American College of Physicians, and the Pan American Medical Assn.

YEOMANS: Una Ritch, Jesup, died January 10, 1954 at her home in Jesup. She was the wife of Dr. J. W. Yeomans, Jesup, sister-in-law of Dr. Neal Yeomans, Waycross, and daughter of the late Dr. Thomas G. Ritch, Jesup.

American Geriatrics Society Meeting

The 11th Annual Meeting of the American Geriatrics Society will be held at the Fairmont Hotel in San Francisco just preceding the meeting of the American Medical Association. The scientific sessions of the meeting will begin Thursday

afternoon, June 17, and continue through Saturday morning, June 19.

Hotel reservations should be made through the San Francisco Convention and Visitors Bureau, 200 Civic Auditorium, San Francisco 2, Cal.

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1. Sayer, R. J., et al.: *Am. J. M. Sc.* 221:256 (Mar.) 1951.

2. Welch, H.: *Ann. New York Acad. Sc.* 53:253 (Sept.) 1950.

3. Werner, C. A., et al.: *Proc. Soc. Exper. Biol. & Med.* 74:261 (June) 1950.

4. Wolman, B., et al.: *Brit. M. J.* 1:419 (Feb. 23) 1952.

5. Potterfield, T. G., et al.: *J. Philadelphia Gen. Hosp.* 2:6 (Jan.) 1951.

6. King, E. Q., et al.: *J. A. M. A.* 143:1 (May 6) 1950.

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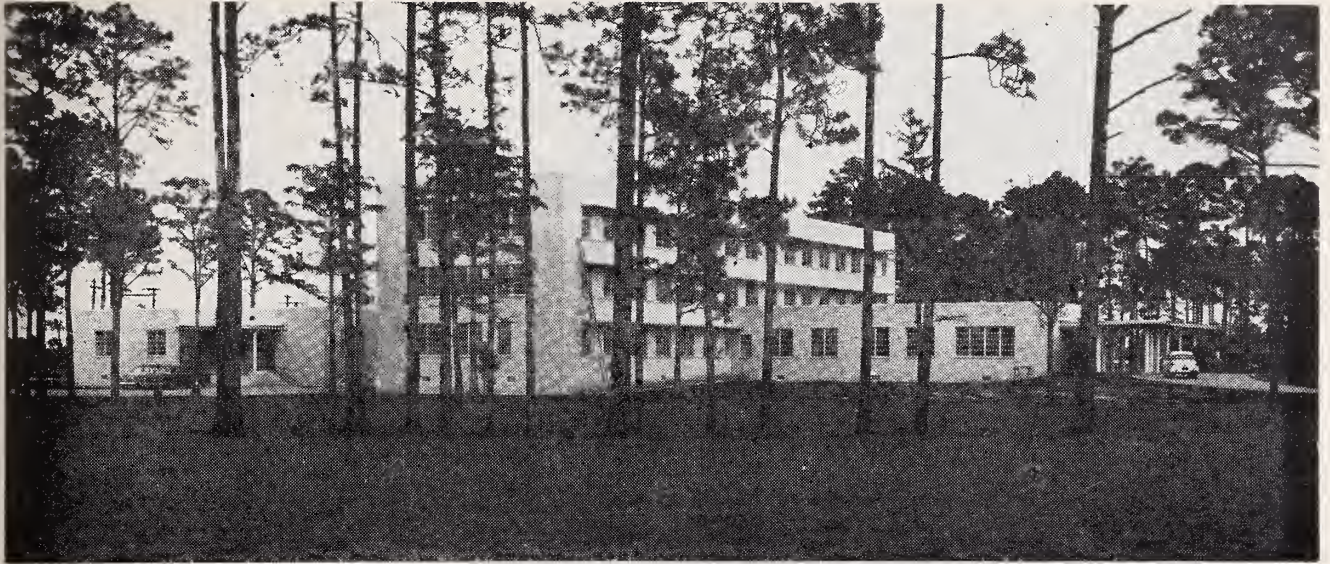
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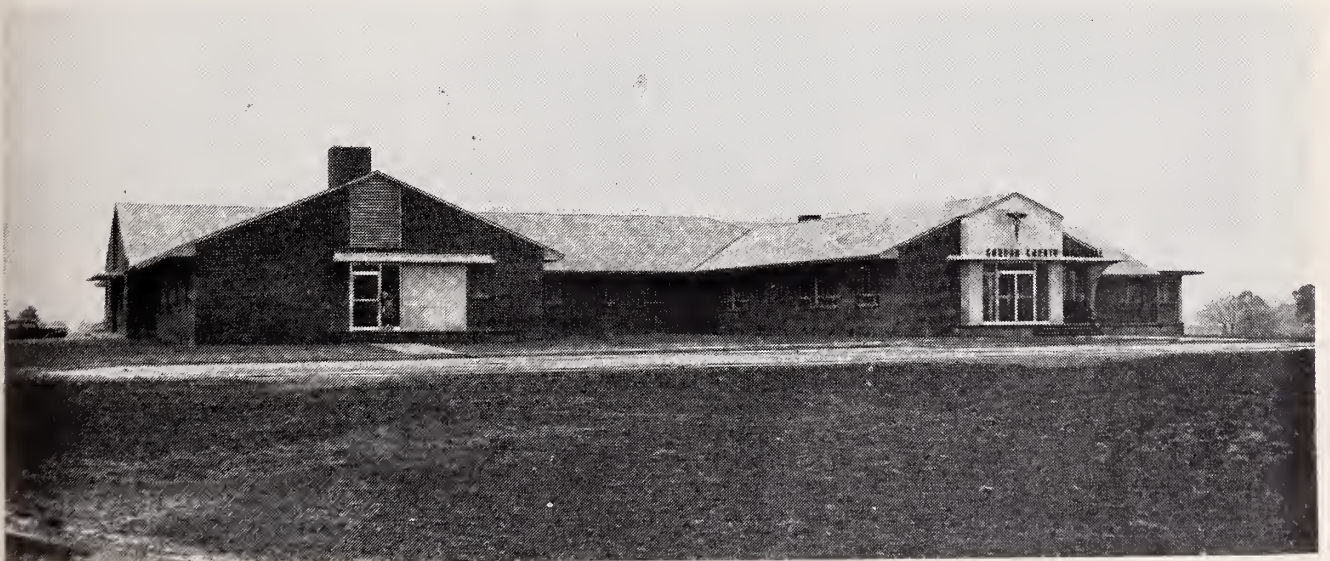
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*Stead, E. A., Jr., in Cecil, R. L., and Loeb, R. F.: Textbook of Medicine, ed. 8, Philadelphia, W. B. Saunders Co., 1951, p. 1065.

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COVER — Photographic Editor, Ted F. Leigh, M.D., examined a dozen door knobs before he found just the right one for the picture you see on our cover. The drawings are by Pat Keel.

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1. Breese, B. B.: J.A.M.A. 152:10 (May 2) 1953

2. Welch, H.: Antibiot. & Chemo. 3:347 (April) 1953

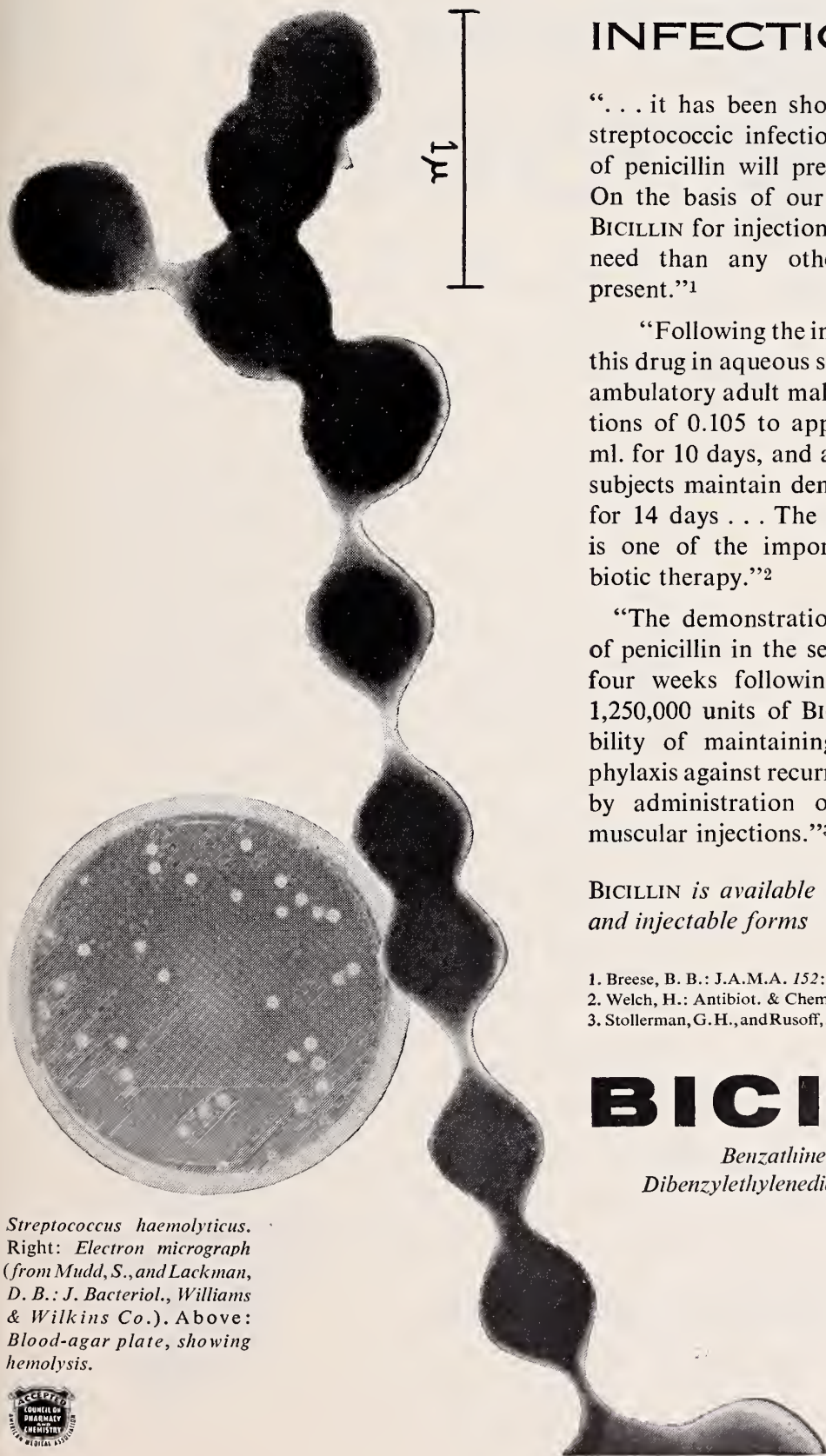
3. Stollerman, G. H., and Rusoff, J. H.: J.A.M.A. 150:1571 (Dec. 20) 1952

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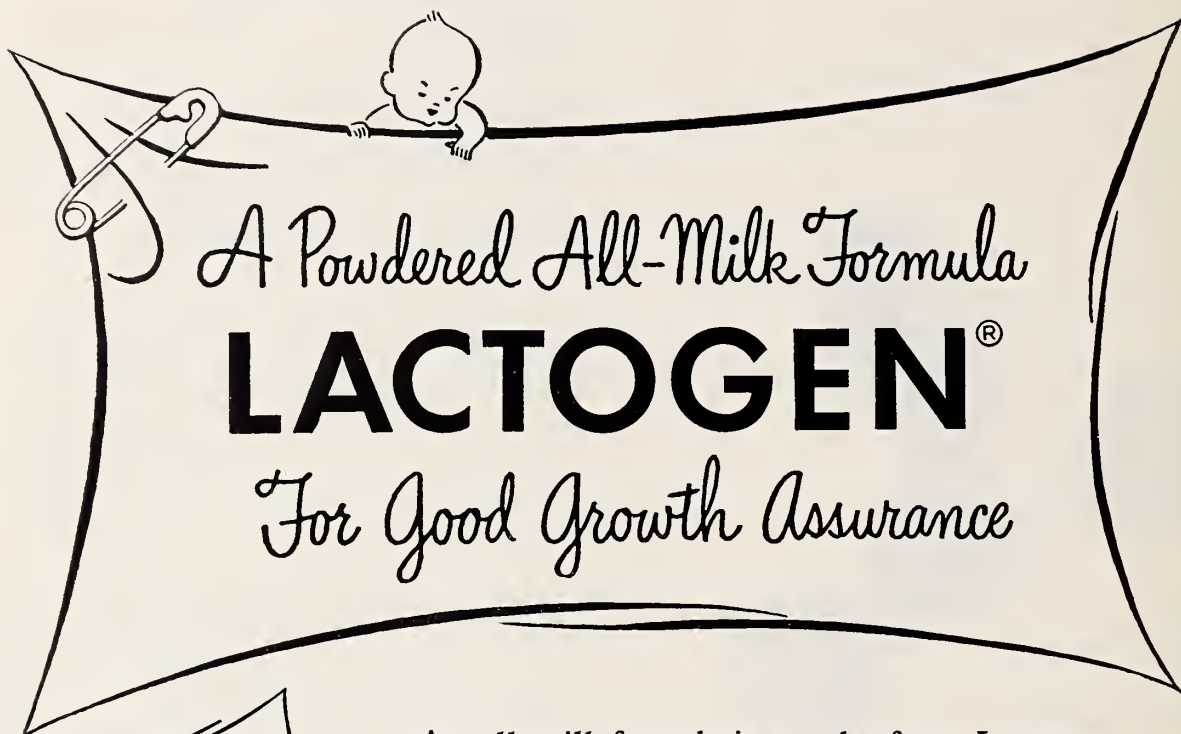


Philadelphia 2, Pa.



Streptococcus haemolyticus.
Right: Electron micrograph
(from Mudd, S., and Lackman,
D. B.: J. Bacteriol., Williams
& Wilkins Co.). Above:
Blood-agar plate, showing
hemolysis.





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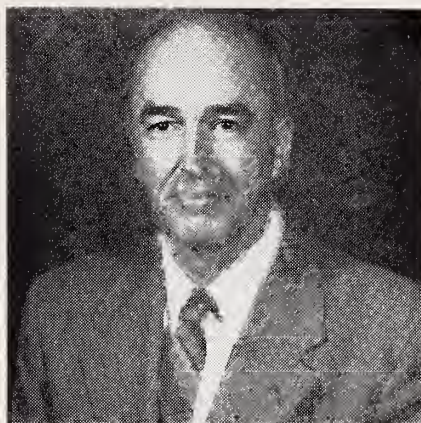
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president's page



Make your plans now to attend the Annual Session of the Medical Association of Georgia in Macon, May 2-5. An excellent scientific program has been arranged, and the sessions have been planned to appeal to the various specialties and to general practice, with many prominent out of state guest speakers participating.

The local committee is doing an outstanding job in providing the facilities to take care of a large attendance and in providing entertainment features which will afford you much pleasure.

As the time draws near to put the reins of the Association in the capable hands of Peter Wright, it is well to pause for a moment and express my appreciation to the many members of the Association who have spent hours of hard work in behalf of organized medicine in Georgia.

The other officers of the Association, members of council, committee chairmen and members deserve much credit for their contributions in time and effort. For them a few words of praise will serve as a token of my appreciation.

WILLIAM HARBIN

physician's bookshelf



BOOKS RECEIVED

Moloney, James Clark, *Understanding the Japanese Mind*, New York, Philosophical Library, 1954, 252 pages, \$3.50.

Kinsey, Alfred C., Wardell B. Pomeroy, Clyde E. Martin, and Paul H. Gebhard, *Sexual Behavior in the Human Female*, Philadelphia, W. B. Saunders Company, 1953, 842 pages, \$8.00.

Sweet, Richard H., *Thoracic Surgery*, (second edition), Philadelphia, W. B. Saunders Company, 1954, 381 pages, \$10.00.

Yorke, E. T., *Salt and the Heart*, Linden, N. J.,

Drapkin Books, 1953, 83 pages, \$3.45.

Jordan, Edwin P., *You and Your Health*, New York, G. P. Putnam's Sons, 1954, 296 pages, \$3.95.

Swartz, Harry, *The Allergic Child*, New York City, Coward-McCann, Inc., 1954, 297 pages, \$3.95.

"The Pre-Adolescent Exceptional Child", Proceedings of the 35th Conference of the Child Research Clinic of the Woods Schools, Philadelphia, May 23, 1953, 66 pages, no charge.

Podolsky, Edward, *Music Therapy*, New York, Philosophical Library, 1954, 335 pages, \$6.00.

"Protoveratrine A and B in the Treatment of High Blood Pressure and Toxemia of Pregnancy", Research Division, S. B. Penick & Company, 50 Church Street, New York 8, New York, 11 pages, no charge.

REVIEWS

An Atlas of Pelvic Operations by Parsons and Ulfelder.

The authors of this atlas of pelvic operations are to be complimented upon their very orderly, concise and accurate presentation of gynecological operative technique and other intra-abdominal operative techniques that the gynecological surgeon should be able to perform. The surgical artist has created an excellent and accurate step-by-step interpretation of the surgical anatomy and technique involved in the various operative procedures.

The importance to the patient and to the surgeon of the absolute necessity of sound gynecological judgment exercised by the surgeon concerning the type of pelvic procedure that will best benefit the patient is emphasized. Fitting the patient to the type of operative procedure that the surgeon can best perform is to be condemned.

The authors have stressed primarily a type of operative technique which has given good results in their clinic. There is no attempt to convert surgeons to the authors' type of technique, but emphasis is placed on the surgeon's following a routine with variation as the occasion arises in order that he shall perfect a routine operative procedure that will give gratifying end-results.

The section devoted to operations involving the intestine is very beneficial in that it will force gynecologists to be more aware of the presence of bowel and to take precautions against injury to it, thus avoiding major complications and future operative procedures because of inadequate treatment initially. Adequate exposure of the operative field, adequate exploration of the entire abdominal cavity, and proper positioning of the patient, of the surgeon and of his assistants is emphasized.

The section on ureteral and urinary bladder injuries is definitely needed in an atlas of this type.

Surgeons are warned of the poor results that may follow incomplete surgery of pelvic malignancy. There is a very nice discussion of this subject and beautiful drawings and concise statements of operative technique necessary to carry out definitive surgical treatment of various pelvic malignancies; however, these surgical procedures are best performed by a skilled team including members of many specialties and should not be done by a surgeon who is not in a situation where by he has such skilled help and facilities.

This atlas is highly recommended to all abdominal surgeons and particularly to gynecological surgeons who frequently are reminded to their own regret and to the patient's regret, of the value of knowing operative technique in the abdomen other than that which is confined primarily to the pelvic organs.

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1. Greenblatt, R. B., and Kupperman, H. S.: *M. Clin. North America* 30:576 (May) 1946. 2. McCavack, T. H., in Goldzieher, M. A., and Goldzieher, J. W.: *Endocrine Treatment in General Practice*, New York, Springer Publishing Company, Inc., 1953, p. 225.

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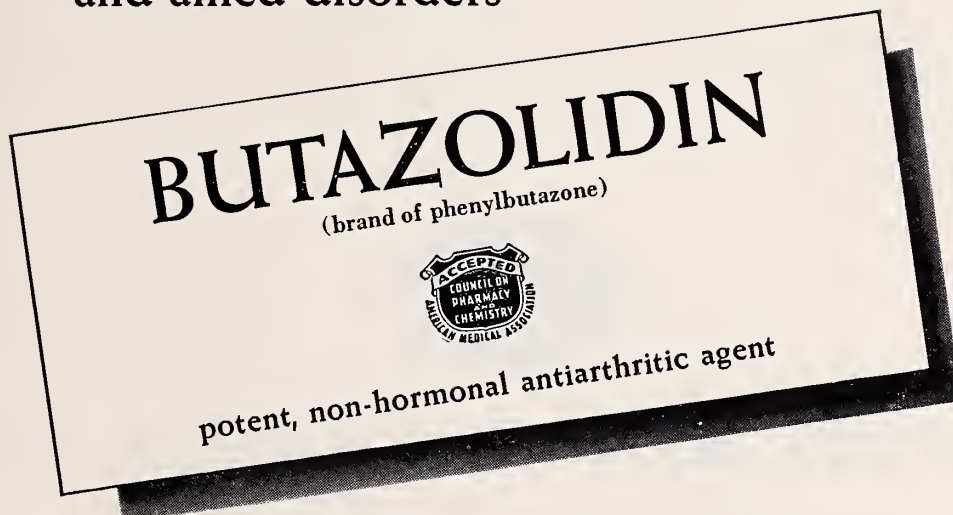
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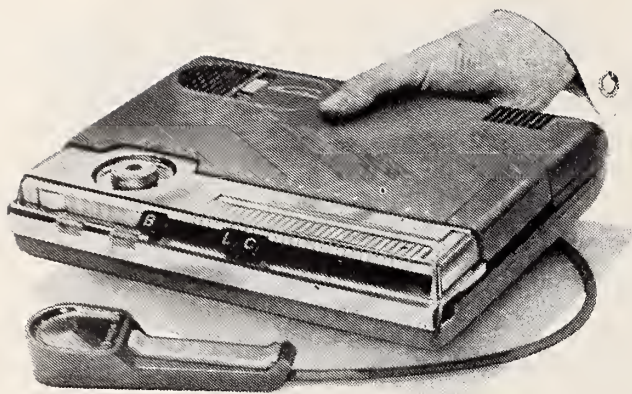
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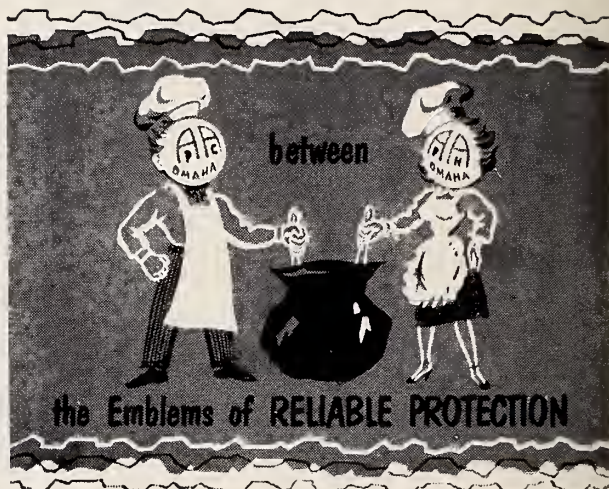
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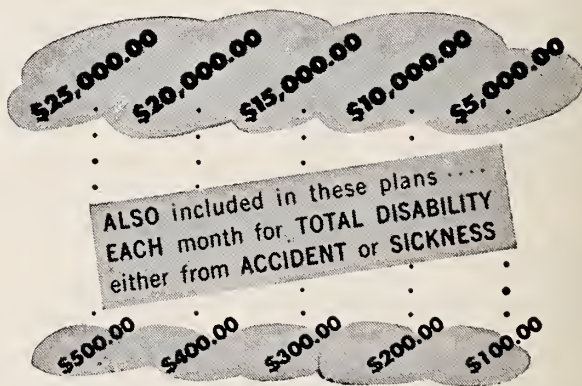
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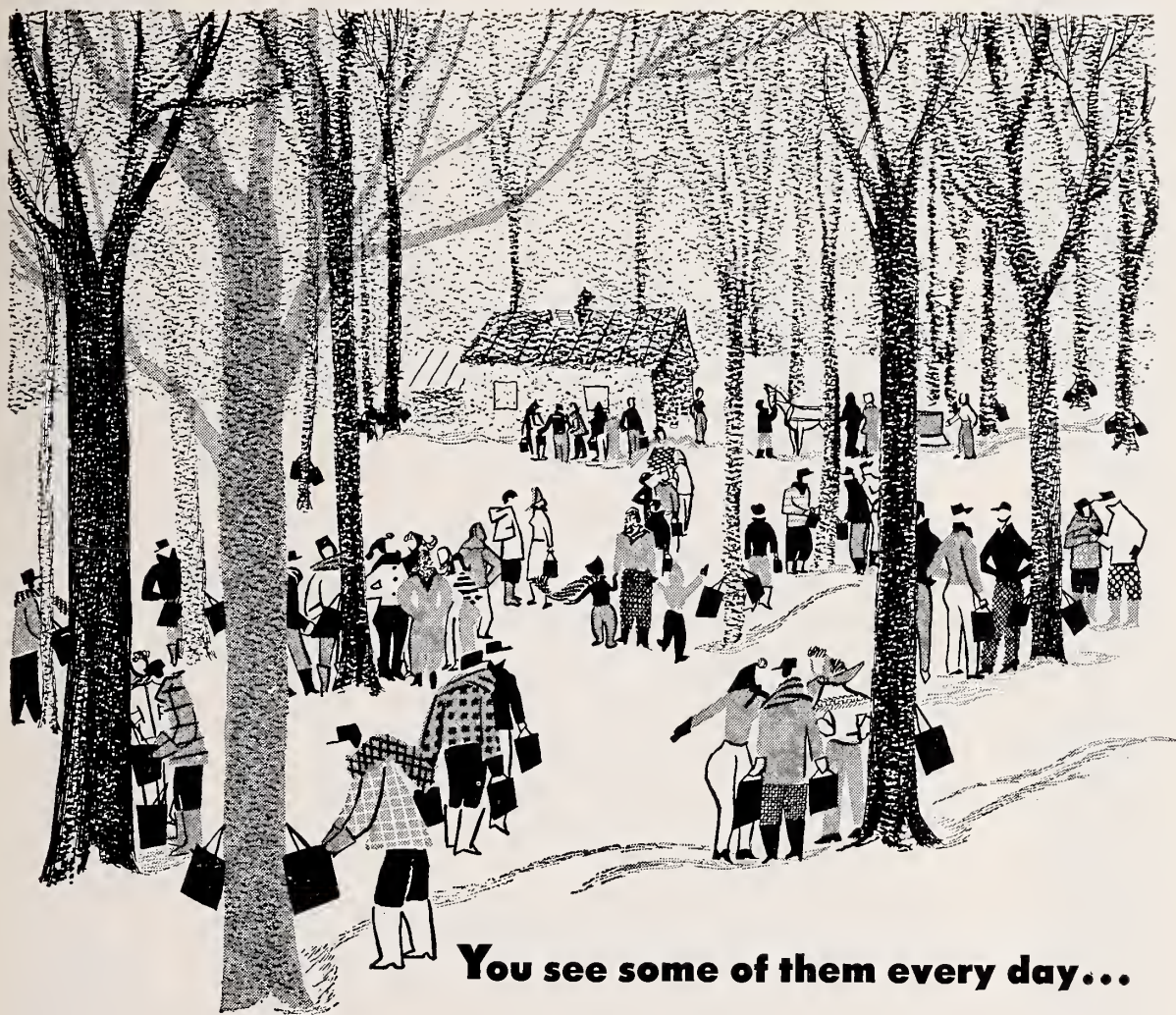
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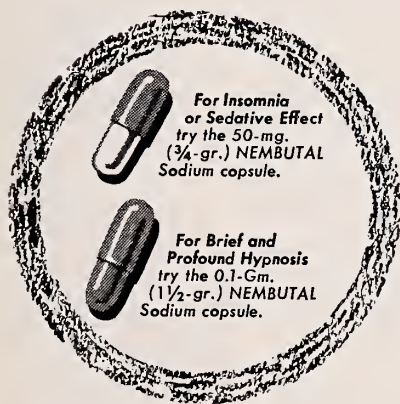
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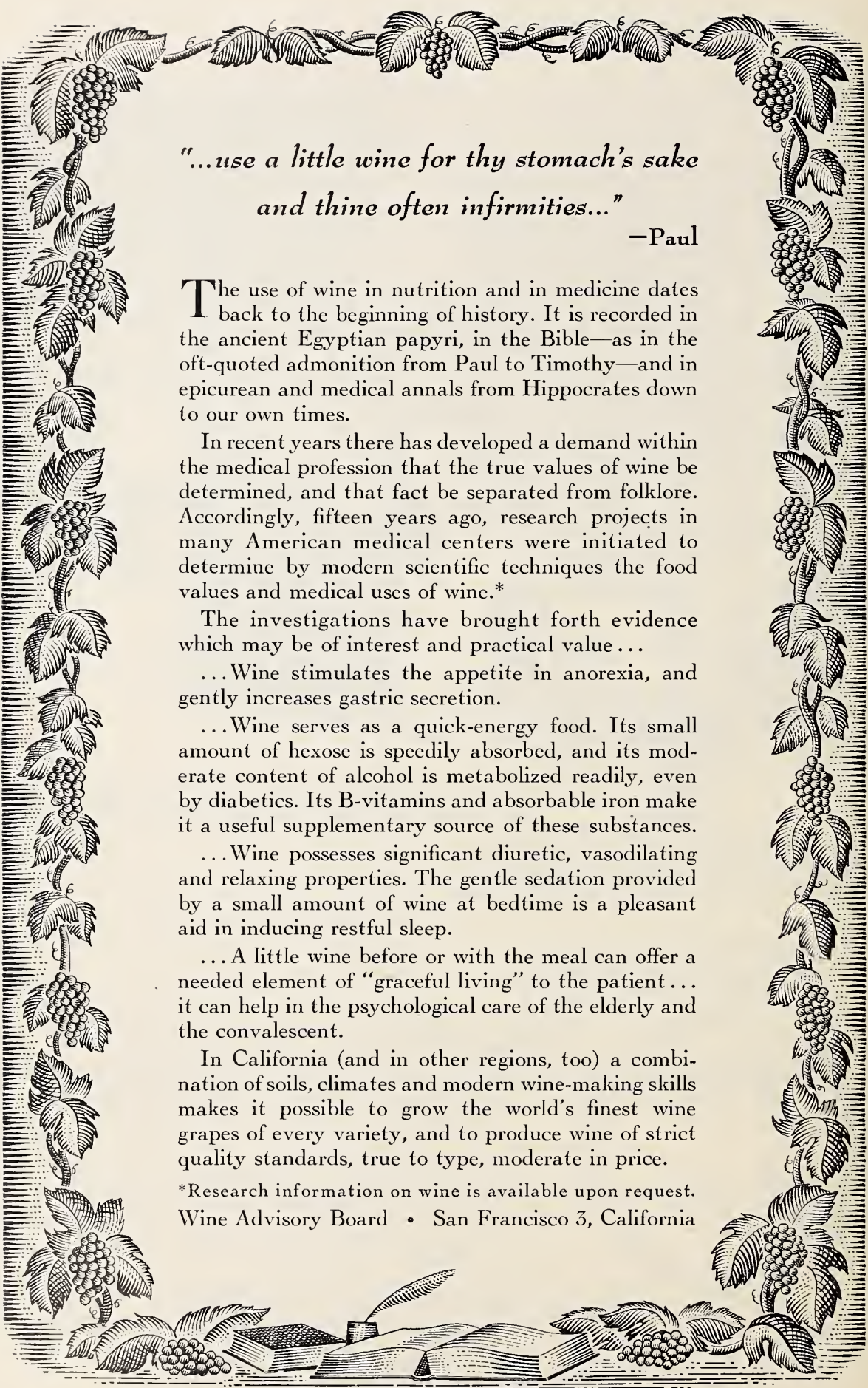


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*"...use a little wine for thy stomach's sake
and thine often infirmities..."*

—Paul

The use of wine in nutrition and in medicine dates back to the beginning of history. It is recorded in the ancient Egyptian papyri, in the Bible—as in the oft-quoted admonition from Paul to Timothy—and in epicurean and medical annals from Hippocrates down to our own times.

In recent years there has developed a demand within the medical profession that the true values of wine be determined, and that fact be separated from folklore. Accordingly, fifteen years ago, research projects in many American medical centers were initiated to determine by modern scientific techniques the food values and medical uses of wine.*

The investigations have brought forth evidence which may be of interest and practical value...

...Wine stimulates the appetite in anorexia, and gently increases gastric secretion.

...Wine serves as a quick-energy food. Its small amount of hexose is speedily absorbed, and its moderate content of alcohol is metabolized readily, even by diabetics. Its B-vitamins and absorbable iron make it a useful supplementary source of these substances.

...Wine possesses significant diuretic, vasodilating and relaxing properties. The gentle sedation provided by a small amount of wine at bedtime is a pleasant aid in inducing restful sleep.

...A little wine before or with the meal can offer a needed element of "graceful living" to the patient... it can help in the psychological care of the elderly and the convalescent.

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the executive secretary's letter

It is with some emotion and yet clarity of purpose that I take the liberty of editorializing a subject conceivably as important as any crisis met in your daily practice of medicine. My concern is with the physician's obligation to his profession—the physician's efforts in his own behalf bent toward keeping the practice of medicine *private*.

—Of Socialized Medicine

Detrimental to the physician's welfare, the theory of socialized medicine is as insidious today as ever before. In a guise more subtle, the profession is faced with strong trends that inevitably lead to a controlled practice of medicine. While these trends are evident on the national scene and are being effectively countered at the present time, their grass roots support has not faded. Many groups in Georgia are successfully striving to sow more of the seed—seed that is being nurtured for eventual fruition which will destroy the present status quo.

—The MAG Answer

The state association can only solve these problems with physicians' support. MAG officers, councilors and committees devote precious hours to planning and effecting policies that serve the physicians of this state. These leaders of the profession make it their business to work in your behalf. On a basis of their time alone spent in committee work, hundreds of thousands of dollars are expended to further your welfare. Unselfishly these few physicians carry the load for each doctor in Georgia. Just a glance at the officer and committee reports that will be presented to the 1954 MAG House of Delegates gives evidence of this tremendous effort.

—Your Obligations

Certainly then it becomes your responsibility to offer more than apathy—to give of your time and effort—and consider it a privilege to serve your profession when called on. Your annual dues should be the least of your contribution. The \$25 MAG dues merely pays for the physical structure, the foundation for your house of medical practice. It is your personal effort that furnishes the house and makes it liveable. Never forget that you inherited this foundation—it was given to you—and with it you assumed the responsibility of its maintenance.

—Your Appreciation

The AMA and, on the more familiar local level, the MAG function solely in your behalf. Their only cause is your cause. These organizations exist to further your interests. Some members may wonder how their interests are represented by an Association in Chicago or by an Association in Atlanta. If they gave the matter more thought it would be obvious that a Georgia physician serving on an AMA or MAG committee *is the policy* of the AMA or MAG. The staffs of these two organizations merely administer the desires of your elected representatives who set the policy.

Then let the Headquarters Office of the Medical Association of Georgia express its sincere appreciation for a job "well done" by those few Georgia physicians who, realizing the value of organized medicine, have accepted the challenge—and by their actions have kept your practice of medicine private. MAG officers, councilors, committeemen; district and county society officers and committees are these few to whom the physicians of Georgia owe so much. These leaders have done your work for you—it's time you assumed your share of the responsibility!

Milton D. Krueger
Executive Secretary

the month in washington

Changes in Hill-Burton Law

Washington, D. C.—Just about a year ago the Hill-Burton hospital construction program was under heavy attack in the House Appropriations Committee. But the damage was not permanent. The program has made a complete recovery. More than that, Congress shows every intention of doubling the appropriation for the program, but earmarking the additional money for grants to diagnostic and treatment centers, rehabilitation facilities, hospitals for the chronically ill, and nursing homes. At this stage the legislation to stimulate health facility construction is believed to be closer to enactment than any other major health project of the Eisenhower administration. Although the main objectives have not been altered, some significant changes were made in the bill by the House Interstate and Foreign Commerce Committee in two weeks of intensive work at closed-door sessions. Then, in mid-March, the Senate committee took up the bill and considered additional amendments.

Most changes are designed to tighten up eligibility for grants. For example, money could go to only two types of diagnostic or treatment centers, those operated by and for a governmental unit or by a group that also operates a nonprofit hospital. Nor would centers or nursing homes be eligible unless under medical supervision or operated by an association that also operates a hospital.

Another change written into the bill would rule out a project if it were not to be open for full and unrestricted use by the general public. Thus labor union, fraternal, and prepayment health plans could not benefit if they offered their own subscribers any advantage in service at the center or hospital.

Prepaid Health Insurance

Of major interest to the medical profession, although not far along on its legislative course, is the administration's proposal for subsidizing prepaid health plans for federal civilian employees. The U. S. would pay a maximum of \$26 per year, to be matched by the employee, for the purchase of any type of prepaid insurance. Any cost above \$52 per year would have to be borne entirely by the employee.

As a part of the program, the administration is proposing that payroll deductions be authorized, a concession the insurance and prepayment insurance organizations have been urging for years. Currently federal executives differ on whether payroll deductions would be "legal," but none is willing to risk authorizing deductions in the absence of specific approval from Congress.

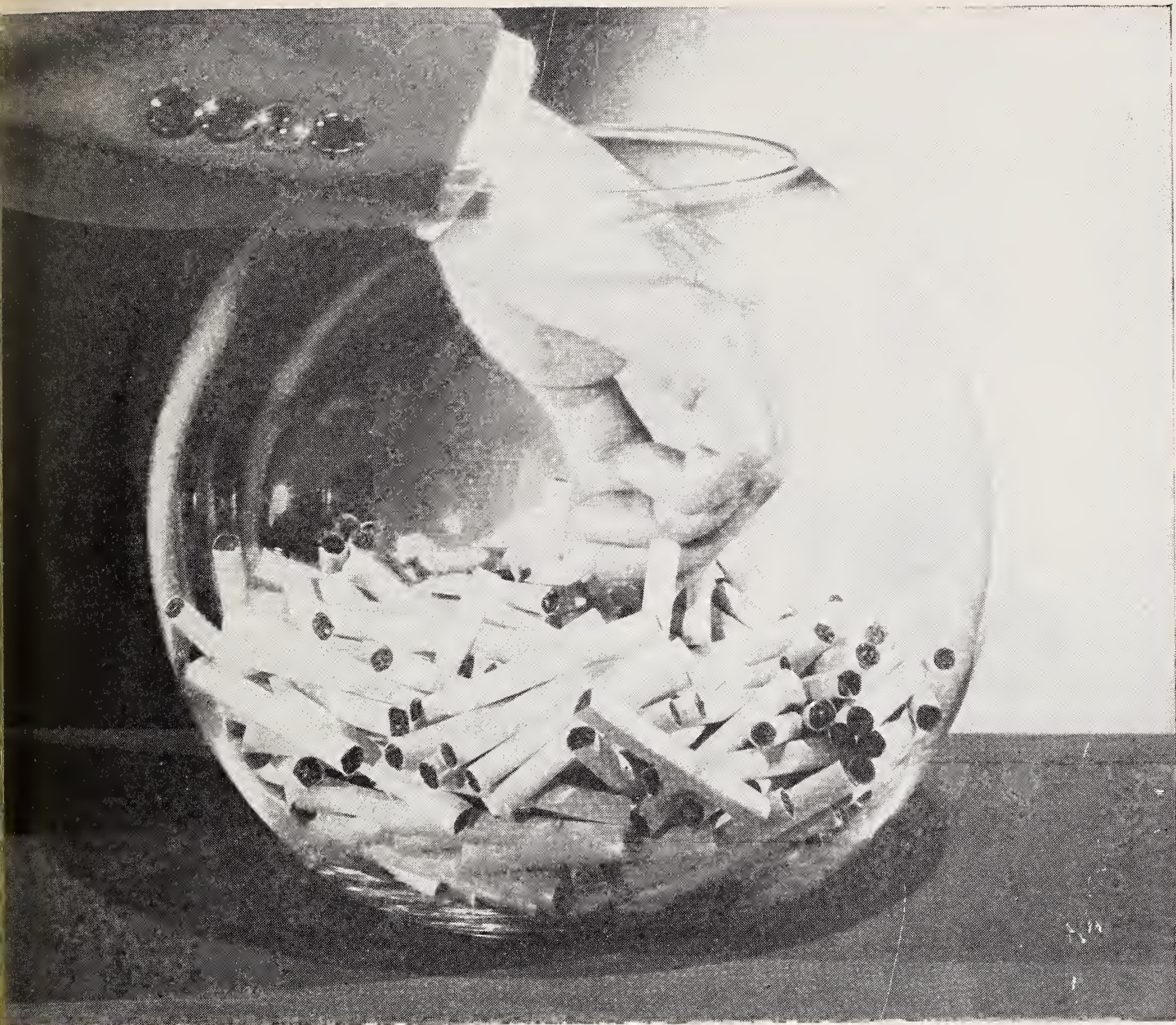
Reinsurance of Health Plans

Still following a slow and controversial course is the administration's proposal for reinsurance of health plans. Early in the session—with the ardent support of Chairman Charles S. Wolverton of the key House committee—this legislation appeared pointed toward enactment. However, the Department of Health, Education, and Welfare was not satisfied with Mr. Wolverton's bill and decided to draft one of its own. The drafting consumed many weeks—time that may prove fatal with a Congress hoping to adjourn early for the fall elections.

Doctor Draft Act Amendment

The Defense Department, made uncomfortable by a few suspected subversive physicians and dentists it doesn't quite know what to do with, is asking for an amendment to the Doctor Draft act. The department's problem is this: The most recent Court of Appeals decision holds that physicians or dentists drafted or called up from the reserves must, under the Doctor Draft act, either be commissioned or discharged. So, technically, a man who refuses to fill out his loyalty questionnaire would be rewarded by a release. To correct the situation, the Department is asking that the law be changed to allow it to withhold a commission from a loyalty suspect, yet keep him on duty for the specified time in noncommissioned status and assigned to professional duties.

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Tobacco and Carcinoma of the Lung

THE EDITORIAL reprinted below from the January 21, 1954 issue of the *NEW ENGLAND JOURNAL OF MEDICINE* expresses our views on the controversial topic: tobacco and carcinoma of the lung. The Editorial is reprinted here in conjunction with three articles in this issue on the same subject: Radiotherapy for Primary Cancer of the Lung, Metastatic Disease of the Lung and Report of the American Cancer Society's Symposium on Lung Cancer.

Your attention is also called to the American Cancer Society's Exhibit, "Cancer of the Lung," which will be presented at the 104th Annual Session of the Medical Association of Georgia, May 2-5, in the City Auditorium, Macon, Ga.

"Present evidence of a correlation between smoking and cancer of the lung was further strengthened by a recent study, which reports a significant production of skin cancer in mice painted with a condensed cigarette tar.¹ Although previous studies had shown that occasional skin cancer is produced in mice and in rabbits with distilled tobacco-tar products, this represents the first record of a significant number of skin cancers caused by a cigarette tar produced under conditions simulating human smoking habits.

It may be asked what significance, if any, such a finding has on the problem of cancer of the lung in human beings. Does mouse skin behave like human bronchial epithelium? Historically, there has been a close association between epidermoid carcinogenesis in mice and men. Studies with coal tar and various petroleum products serve as a good example. When this particular question is considered, however, it must be stressed that the animal experiments were undertaken because of the human evidence already at hand.

"Today, thirteen separate studies from six different countries, involving more than 5000 patients, all point to a correlation between smoking and cancer of the lung. More than a year ago, in a symposium on lung cancer sponsored by WHO and UNESCO, such an association was regarded as established.² The statistical association is considered to have etiologic significance because it is compatible with the present sex ratio and incidence pattern of pulmonary cancer³ and the urban-rural distribution, as well as the fact that this association could not be readily explained upon any other

basis. The association between smoking and cancer of the lung does not deny the significance of other factors. Individual predisposition is of undoubted importance although its nature is not understood. Some occupational exposures seem to lead to higher than expected risk. Air pollution has been mentioned as an added factor, although statistical clinical proof is lacking. As a matter of fact, Doll⁴ recently pointed out that a non-smoker in a city has as little chance of acquiring cancer of the lung as a nonsmoker living in a farm area.

"Even though the role of other etiologic factors is recognized the fact remains that statistical clinical data show that nonsmokers rarely have lung cancer, whereas the risk increases directly with the amount of tobacco smoked. It is because of the extensive human evidence that the new experimental data gain significance.

"According to the authors of this investigation the primary purpose of experimental tobacco-tar studies is not so much to confirm or deny human data, which they believe must stand essentially on their own merits, as to serve as a research tool for the possible identification of actual carcinogens in tobacco tar. At present it can only be speculated that these agents will be the same as those affecting man. Such work of identification could only be done with the laboratory animal.

"Thus, because of the massive clinical statistical evidence collating smoking to cancer of the lung and because of the ever-increasing incidence, further experimental work that may lead to the identification and possible removal of carcinogenic agents from tobacco tars appears most urgent. It might be timely for the manufacturers of cigarettes, some of whom have adopted the policy of discrediting this obvious association, to take an even more active interest in the detection and elimination of the carcinogenic factors."

REFERENCES

1. Wynder, E. L., Graham, E. A., and Croninger, A. Experimental production of carcinoma with cigarette tar. *Cancer Res.* 13:855-864, 1953.
2. Council for the International Organizations of Medical Sciences under the auspices of the World Health Organization. Recommendations Adopted by the Symposium on the Epidemiology of Cancer of the Lung. *Cancer Res.* 13:471-475, 1953.
3. Clemmesen, J., Nielsen, A., and Jensen, E. Increase in incidence of carcinoma of lung in Denmark, 1931 to 1950. *Brit J. Cancer* 7:1-9, 1953.
4. Doll, R. Mortality from lung cancer among non-smokers. *Brit. J. Cancer* 7:303-312, 1953.

A Question of Ethics

HOW MANY PHYSICIANS in Georgia own full or part interest in pharmaceutical firms, drug stores, surgical supply houses or related medical businesses? Many physicians have never considered the possibility that such ownership might be unethical. In many cases it is not unethical—but if any doubt exists concerning a physician's receiving rebates or "kickbacks" on drugs or appliances in the form of a percentage of profit, then the entire profession suffers.

Where can the line be drawn? The AMA *Principles of Medical Ethics*, Chapter I, Section 6, states: "The acceptance of rebates on prescriptions or appliances, or of commissions from attendants who aid in the care of patients is unethical. An ethical physician does not engage in barter or trade in the appliances, devices or remedies prescribed for patients, but limits the sources of his professional income to professional services rendered the patient." And Chapter VIII, Section 3 states: "Physicians should recognize and promote the practice of pharmacy as a profession and should recognize the cooperation of the pharmacist in education of the public concerning the practice of ethical and scientific medicine."

The Judicial Council of the AMA feels that a physician should not have a financial interest in a pharmacy or related business within the vicinity of his practice. It is not ownership per se that is objectionable, unless by that ownership a physician uses his position in the profession to further his private business gain. We can also interpret this opinion to include a surgical supply house that operates within the physician's trade area. But what constitutes a physician's trade area? And what actually constitutes abuse of a physician's professional relationship with his patients?

Many physicians may not be cognizant of the difference between ownership of stock in a national pharmaceutical house and part ownership of a local company. In the case of the national

firm, stock is bought and sold on the open market. But in the case of a local firm, stock is often owned only by physicians. Frequently the local firm is a closed corporation and its stock is not for sale on the open market.

Does the difference lie in the fact that the corporation is open or closed? We believe this to be a moral question—that fact that the physician is tempted to prescribe the products of his own company when that company is small and therefore more affected by his individual actions. Profits from the sale of products of small closed companies will necessarily be divided among a few individuals. Indeed, the action of an individual physician may directly affect his income. In the case of large national concerns, the individual stockholder does not have an opportunity to profit directly from local patronage. When the physician receives profit from drugs or medical appliances he prescribes for his patients, is he not in reality receiving a rebate?

Another problem on the local level is the drug store. Is it unethical for a physician to rent space to a pharmacist in a situation where there is no established apothecary in a small town? This could also apply to a pharmacist's rental of space in a clinic. The Judicial Council maintains that when physicians lease such space on a sliding scale or for a percentage of the income received by the pharmacy, the result is equivalent to receipt of a rebate from each prescription. This is unethical, the Council declares.

We as physicians may be called upon to help define where the line should be drawn. During the coming Annual Session in Macon, May 2-5, Homer Pearson, a member of the Judicial Council of the AMA, will address the House of Delegates. He will endeavor to answer some of these questions so that the Association may, through the cooperation of its members, adopt a clearcut policy.

Regional Health Conference

The Better Health Council of Georgia is sponsoring a one-day Regional Health Conference in Swainsboro, Ga., on Wednesday, May 12. The round-table discussion will center on Mental

Health in all of its phases. This meeting will include the 26 counties in the east central region.

Mrs. C. E. Powell of Swainsboro is chairman of the Regional Health Committee.

MACON SECTION



Welcome to Macon

MILFORD B. HATCHER, M.D., Macon, Ga.



“**C**ALLING ALL PRACTITIONERS of medicine in the State of Georgia to meet in the hall of the Tomochichi division, Sons of Temperance, Macon, Ga., March 20, 1849.” The object of this meeting was to organize the medical society of the State of Georgia. Appreciating the importance of this event, the three railroads of the state reduced the fare by one half for all physicians attending the convention. The meeting was held as scheduled, and the state medical society was organized. It was voted to have an annual meeting.

Although there have passed 103 annual sessions of the Medical Association (Society) of Georgia, we still have the same obligations of

many eminent physicians from Hippocrates to this present day. The physician must continue to hold his zeal, talents, attainments and skill in trust for the general good. As physicians we should be impressed with the nobleness of our vocation, with our responsibility as trustees of science and as almoners of benevolence and charity. Many delusions are sometimes manifest in the guise of new and infallible systems of medical practice. We should ever investigate the true science and facts. Incompetency and presumptuous pretending should be eradicated, and we should fill our armamentarium with scientific facts and medical knowledge along with thought and common sense. Attending one of these meetings is one of the best methods of accomplishing these purposes.

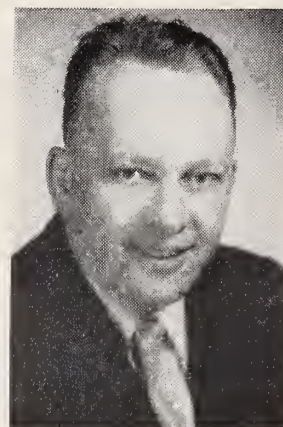
In behalf of the Bibb County Medical Society, I invite you to Macon for the 104th annual session, which will be held on May 2 through May 5 at the Macon City Auditorium. All members are urged to drink from the fountain of knowledge by attending the scientific sessions during the day and to enjoy good fellowship, fun and entertainment at night.

Since organization of the Medical Society of the State of Georgia, Macon has been the host city more than any other city in the state. As the 104th annual session is to be held here, we cordially invite each and every one of you to come and join us in making this the best session ever.

Milford B. Hatcher, M.D.

President, Bibb County Medical Society

Macon Newspaper Editor 1



JOE PARHAM, Editor, The Macon News

HOW DO YOU WRITE about a city? What can you say about the town you love? How do you express the fierce pride and abiding affection you feel for a community?

It starts, I guess, like most other things, with people. Every city has people. Every city has the rich and the poor, the tall and the short, the white and the black, the bad and the good. But Macon seems to have been blessed more fortunately than most communities with citizens—of all races, creeds and religions and of all economic and social levels—who have a keen zest for pleasant living and a deep sense of responsibility for community welfare.

Perhaps that's because Maconites live a little closer to the Almighty than a lot of folks in a lot of towns. They call this a "City of Many Churches," you know. There are more than 147 temples for worship, an average of one to every 650 inhabitants, and religious census figures show that approximately 78 per cent of the population are church members.

That's one picture to paste in your memory scrapbook of Macon: a sunny Sunday morning, church bells ringing lazily in the distance, a soft, sweet breeze kissing the faces of all the papas and mamas and children, dressed in their "go-to-meeting" best, on their way to worship at the throne of He who provides all good things. They pause—this church-bound family—and talk briefly and laugh with neighbors and smile and nod to friends met.

There's another thing about Macon—the friendliness. You take Atlanta and it's big and sassy and just a little bit like a prosperous hussy. Folks are in too much of a hurry or there are too many people on the streets to have much chance to talk to an old friend in Atlanta. And Savannah, there's a city that's a haughty dowager. You'd be embarrassed and afraid of inviting a snub if you smiled at a stranger in Savannah just because you wanted to smile for the sheer joy of living.

But Macon, ah, not in Macon. We trade smiles and pleasantries downtown like we swap nickels and dimes, and a gloomy frown is strictly counterfeited. You doctors try an experiment while in Macon. Smile at a stranger on any street corner. If a smile just as big, just as cheerful and just as friendly as the one you gave doesn't come flashing back, I owe you the finest stethoscope money can buy.

Maybe Macon people are friendly and happy because Old Mother Nature was mighty kind to

us. She gave us a mild climate with an average mean monthly temperature of 64.5 degrees. That's just right for a long growing season, with attendant natural beauty and agricultural prosperity, but still leaves room for a little nip of cold in the wintertime, so you'll appreciate the spring and summer and autumn more.

Mother Nature distributed her bounties with a lavish hand. Rich, fertile soil. Plenty of water underground and a lazy, lovely river winding by. Mineral wealth in profusion and rainfall in just the right amount to touch the soft and lovely cheeks of the peaches in the orchards we're so famous for and the pretty girl peaches we're so proud of.

Beauty? Sure, Columbus and Augusta and Albany and other Georgia towns have got their share of pretty girls. But, in Macon, with Wesleyan College, the first in the world to grant a degree to women, situated close by, we're happy to have even more than our share. Matter of fact, in all seriousness, I warn attending physicians who are bachelors against going out unless accompanied by colleagues here lest they be smitten by a beautiful damsel and headed for the altar before the concluding session of the convention.

Our Town

Why He Likes His Home Town

Editor Parham says: "You doctors try an experiment while in Macon. Smile at a stranger on any street corner. If a smile just as big, just as cheerful and just as friendly as the one you gave doesn't come flashing back, I owe you the finest stethoscope money can buy."



Left, Colonial house in Macon and right, Wesleyan College campus.

While talking about Wesleyan, let us not forget to mention some other facts on the subject of education. Macon boasts of Mercer University, the oldest school of Christianity in the South, and a college widely recognized for its pre-medical and military science and tactics training and its courses in law and science and the liberal arts. In turn, Wesleyan is famous for both its high scholastic requirements and conservatory of fine arts.

Education isn't spelled with a capital "E" only on the college level in Macon either. The Bibb County school system, with an enrollment of 23,000 students and splendid equal facilities for both white and colored, is a model setup praised and studied by educators from all over the world. There are, of course, other fine educational institutions, either privately operated or run by religious groups or the state, over the city but they are too numerous to mention.

Possibly all this emphasis on adequate education comes about because the people were smart enough to be born or raised in Macon in the first place.

You ask, "What is so special about Macon?" and I could answer in many ways. I could point

to the beautiful homes and the gracious living. I could cite the fact that the prosperity of the community is nicely balanced on a base of agriculture and industry. I could say that Macon is a natural transportation center, in the heart of the state, with five railroad lines, three airlines, 18 motor freight routes and four bus lines radiating out, like the spokes of a wheel, in every direction.

I could give you the answer given a friend of mine by a visitor from New York City recently. "Always thought Southerners were naturally slow," he said. "But here I've discovered you have an amazing combination of leisure and vitality. You know how to work swiftly and efficiently when it is time for that, and you know how to relax and play when it is time for that." In a visit of just a few days to Macon, he had learned our secret which is so valuable and which so many people will never learn.

Statistics? I could get them from the Chamber of Commerce and reel them off by the yard. But nearly everyone knows about our city's well-organized recreational facilities with the 22 parks and playgrounds and the excellent 18-hole municipal golf course and the perfect Idle Hour Country Club with its famed 18-hole layout. And

there's no news in the fact that Macon's location makes it an ideal convention city with the Municipal Auditorium seating 4,500 available and twelve hotels providing 1,250 rooms and 27 approved motor courts in the vicinity.

Likewise, the community's role as a defense center is well known. When Uncle Sam yelled, "Johnny, get your gun!" back on Pearl Harbor day more than 12 years ago, the Macon Johnnys and Jennys grabbed. The boys went overseas and the girls did their part and, back home, the folks tightened their belts and went to work in the war plants. One of those military installations is still with us, and we show off Robins Air Force Base as proudly as our other assets. It is a permanent U. S. Air Force center located a few miles south of Macon, providing a home for the 14th Air Force Headquarters and for the Warner Robins Air Materiel Area Headquarters, where planes of all types and shapes are flown for repair and rebuilding.

All of these things, and many more, could be stated in answering a query as to what makes Macon so special. But it is the sum total of all these things that make our community a great place in which to live.

When did it all start?

Long, long ago. Thomas Jefferson and John Adams and some other of the founding fathers were still alive when Macon was incorporated in 1823. For some years, there had been settlers living close-clustered for protection against Indians near Fort Hawkins, a frontier port established by President Jefferson at the head of navigation on the Ocmulgee River. They wanted a city and they named it in honor of Nathaniel Macon, a North Carolina statesman who was at the time being prominently mentioned as a possible candidate for the vice presidency in the approaching elections.

Those who laid out the town insisted on wide streets and spacious parks, and present day residents may thank them for their foresight. By late 1824, the new town had a school and "twenty respectable stores," according to historical records. It might be noted that none of the 20 were grog shops and, even today, Macon is noted as being one of the cleanest (both morally and physically) cities in the state.

By 1831, there was a population of 2,600 per-

sons and by March 20, 1849, when the organization meeting and founding of the Medical Association of the State of Georgia was held here, Macon was the railroad center of the state and counted a population of only a few less than 5,000.

The years marched past. The Indian threat was removed and rail lines were pushed northward toward a little village less than a hundred miles away which was to be called Atlanta. The War Between the States came and for a time Macon became the temporary capital of Georgia. On April 20, 1865, the city was forced to yield to the pressure of Union forces and surrendered.

Perhaps the city instilled iron in its backbone by keeping its chin high and its shoulders straight through the rigors of Reconstruction. But who can say whether a city is born with character or whether it is picked up along the way through the roll call of the years? Suffice it to say that over the decades which followed Macon did not grow as rapidly as her neighbor to the north in population but what was lacking in quantity was more than made up in quality. The village begun by a stake being driven into muddy ground near the banks of the Ocmulgee blossomed into a fair and lovely city whose citizens revered honor, respected integrity and loved God. They managed, somehow, by some mysterious alchemy, to more than halfway meet the industrial age and yet at the same time to retain much of the charm, the culture, the graciousness and the beauty of an age which began dying with the first shot at Fort Sumter.

But a city's stature cannot be measured by its birthdays, nor can age alone attest to its good works. Only people can do that. Only friendly, honorable, proud people.

Which seems to bring us back to where we started. To the people of Macon, to the folks who are a part of a great community. And perhaps I have not answered the question this article began with—the question of how to tell the story of a town and express your love for it and show your fierce pride in its courage and your calm confidence in its strength.

There are many things left unsaid, which ought to have been said. But I do not really know how to go about telling the story of a city. You love it, like many thousands of others love it, and that's all there is to it.

104TH ANNUAL SESSION MEDICAL ASSOCIATION OF GEORGIA MACON, GA., MAY 2-5, 1954

Official Call

TO THE OFFICERS AND MEMBERS OF THE MEDICAL ASSOCIATION OF GEORGIA

The 104th annual meeting of the Medical Association of Georgia will be held in Macon, Ga., May 2-5, 1954.

The House of Delegates will convene at 2 p.m. Sunday, May 2 in the Main Floor of the Macon City Auditorium.

The Scientific Sessions of the Association will open Monday, May 3 starting at 8:15 a.m. with a General Session at 10:45 and a General Clinical Session at 2:15 p.m. The Inaugural Meeting, at which the President and new officers will be installed, will be held at a Final General Session at 2:30 p.m. Wednesday, May 5. The sections will meet Sunday, Monday, Tuesday and Wednesday, May 2, 3, 4 and 5 as follows:

Sunday at 2 p.m.

Radiology
Anesthesiology

Monday at 8:15 a.m.

Radiology Anesthesiology
Urology Pediatrics and Orthopedics

Tuesday at 8:15 a.m.

General Practice & EENT Pathology
Industrial Surgery and Internal Medicine
Medicine Obstetrics and Gynecology

Wednesday at 8:25

Joint Section Surgery and Thoracic Diseases
Internal Medicine

The official Registration desk, located in the East Corridor, Main Floor, Auditorium, will be open for Registration of MAG members and guests at 3 p.m. Sunday and at 8:15 a.m. on Monday, Tuesday and Wednesday.

William Harbin, President
David Henry Poer, Secretary-Treasurer

CONVENTION COMMITTEES

Bibb County Medical Society Medical Association of Georgia May 2-3-4-5, 1954

General Committee

Willard R. Golsan, *Chairman*
Milford B. Hatcher Henry H. Tift

Entertainment Committee

Thomas L. Ross, Jr., *Chairman*
Robert W. Edenfield Robt. W. McAllister

Finance Committee

Henry H. Tift, *Chairman*

Visual Aids Committee

Max Mass, *Chairman*
Herbert M. Olnick J. T. Hogan, Jr.

Publicity Committee

Thomas E. Rogers, Jr., *Chairman*
Benham Stewart W. D. Hazelhurst

Hotel Reservations Committee

Leon D. Porch, *Chairman*
Charles T. Rumble Allan A. Cole

Transportation Committee

Charles L. Ridley, Jr., *Chairman*
E. C. McMillan, Jr. William R. Birdsong

Registration Committee

William W. Baxley, *Chairman*
William K. Jordan Joe W. Daniel, Jr.

Liaison with Woman's Auxiliary Committee

Frank M. Houser, *Chairman*
Holloway Bush J. Lon King, Jr.

Golf Committee

Carl L. Anderson, *Chairman*
Jerry P. Woodhall Ernest Corn

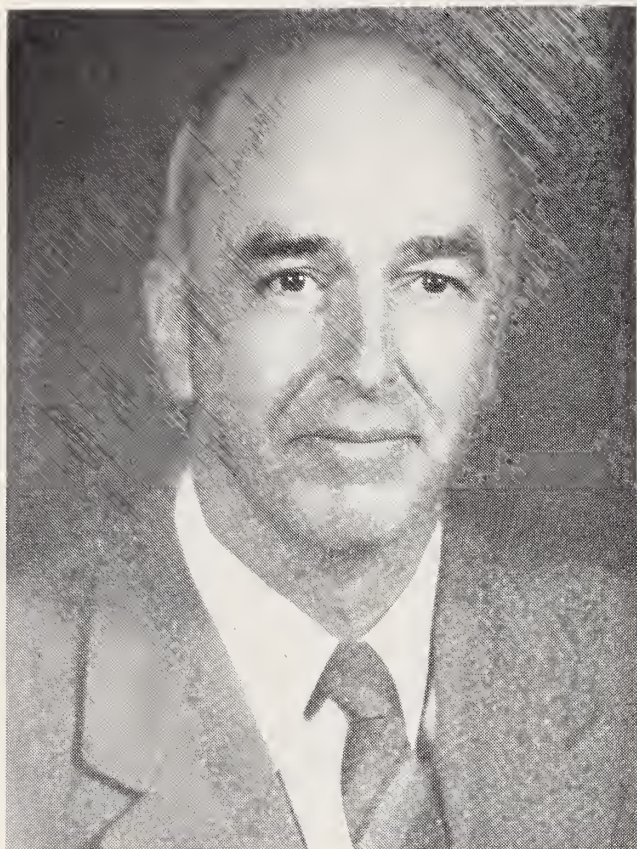
Hospitality Committee

Charles H. Richardson, Sr., *Chairman*
Thomas Harrold William Holden

Luncheons and Special Dinners

Emory University.....	Edmund A. Brannen
University of Georgia.....	William L. Barton
Tulane University.....	Henry H. Tift
Georgia Chapter, American College of Surgeons.....	Charles N. Wasden
Georgia Urological Society.....	Willard R. Golsan
Gbstersics and Gynecology.....	Jule C. Neal
Georgia Chapter, American College of Physicians.....	Harold C. Atkinson
Georgia Academy of General Practice.....	Frank M. Houser
Georgia Pediatrics Society.....	William C. Boswell
Georgia Industrial Surgeons.....	Charles N. Wasden
Georgia Radiological Society.....	Herbert M. Olnick
Georgia Society of Ophthalmology and Oto-Laryngology.....	William L. Barton
Georgia Association of Pathologists.....	Max Mass
Georgia State Society of Anesthesiologists.....	E. L. Fry
Georgia Orthopedic Society.....	Walter P. Barnes, Jr.
Georgia Chapter of Chest Surgeons and Georgia Trudeau Society.....	Sam E. Patton

OFFICERS FOR 1953-1954



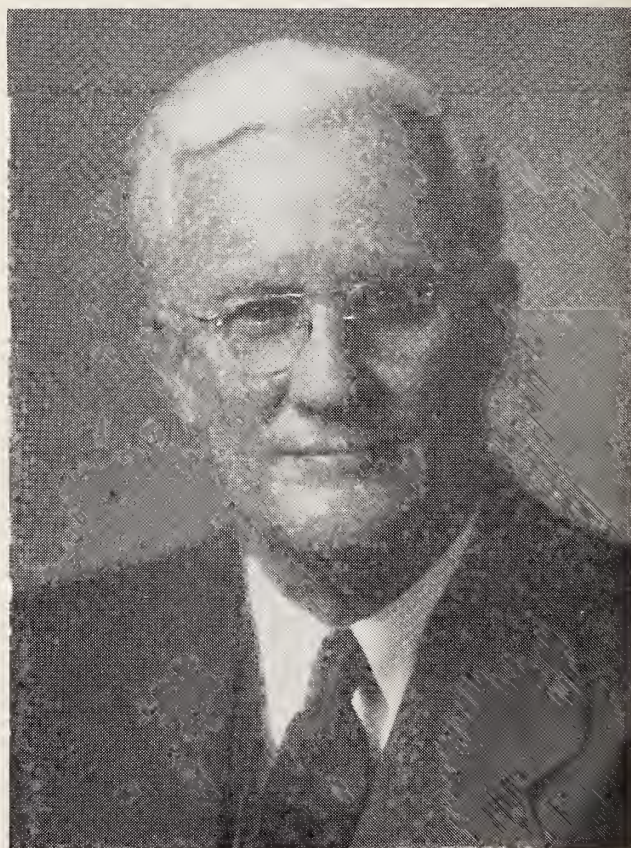
William Harbin, President



Milford B. Hatcher
Second Vice-President



James C. Metts
First Vice-President



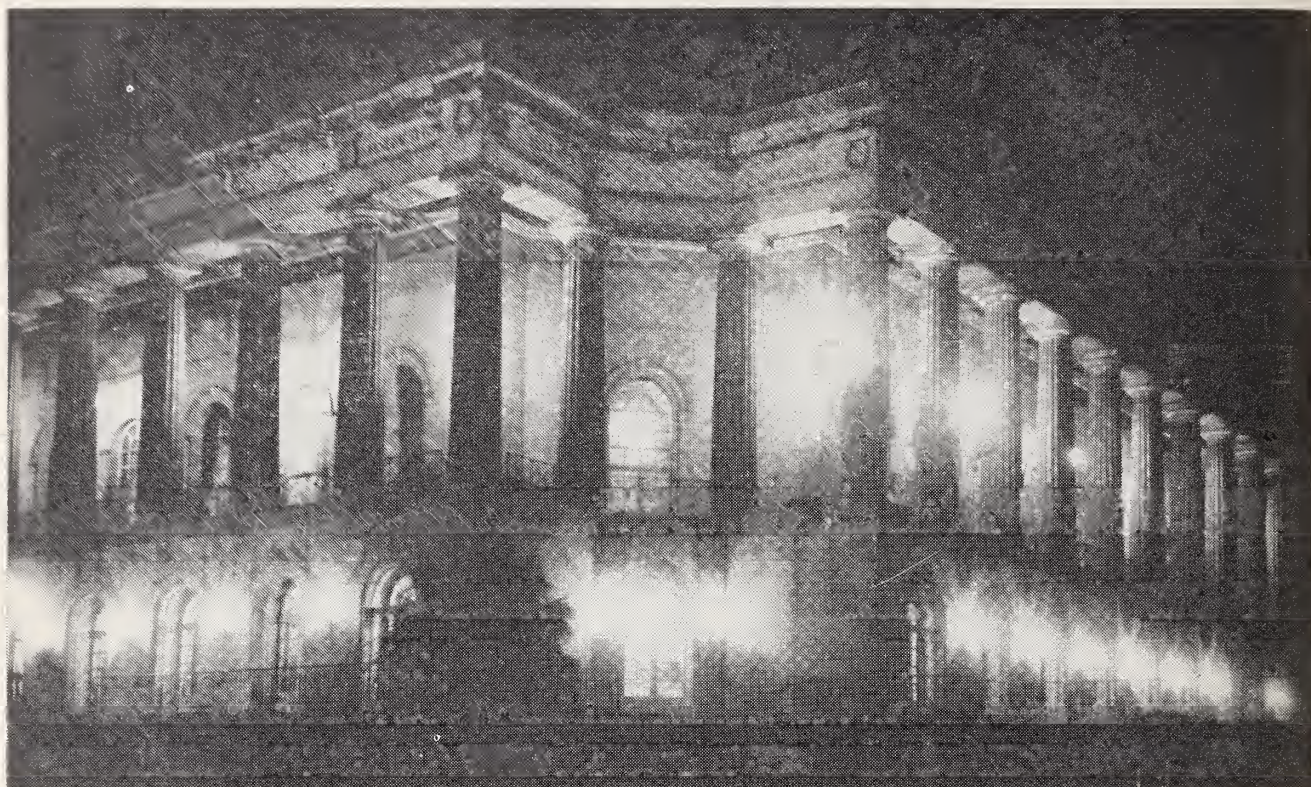
David Henry Poer, Secretary-Treasurer

President Elect



Peter B. Wright

Peter B. Wright, President-Elect



Night view of Macon City Auditorium where the Annual Session will be held.

OFFICERS FOR 1953-1954

President—William Harbin, Rome
 President-Elect—Peter B. Wright, Augusta
 First Vice President—James C. Metts, Savannah
 Second Vice President—Milford B. Hatcher, Macon
 Secretary-Treasurer—David Henry Poer, Atlanta

Delegates to the A.M.A.

Terms Expire December 31, 1955

C. H. Richardson, Sr., Macon
 C. L. Ayers, Toccoa, Alternate

Terms Expire December 31, 1954

Eustace A. Allen, Atlanta
 William R. Dancy, Savannah, Alternate

Executive Committee

William Harbin, President, Rome
 David Henry Poer, Secretary-Treasurer, Atlanta
 Mark S. Dougherty, Jr., Member of Council, Atlanta
 H. L. Cheves, Chairman of Council, Union Point
 George R. Dillinger, Member of Council, Thomasville

Committee on Auditing and Appropriations

J. W. Chambers, Chairman, LaGrange
 D. Lloyd Wood, Dalton
 Mark S. Dougherty, Jr., Atlanta

Councilors

<i>District</i>		<i>Term Expires</i>
1—	Lee Howard, Savannah	1955 Session
2—	George R. Dillinger, Thomasville	1955 Session
3—	W. G. Elliott, Cuthbert	1955 Session
4—	J. W. Chambers, LaGrange	1955 Session
5—	Mark S. Dougherty, Jr., Atlanta	1956 Session
6—	H. Dawson Allen, Jr., Milledgeville	1956 Session
7—	D. Lloyd Wood, Dalton	1956 Session
8—	Neal F. Yeomans, Waycross	1956 Session
9—	W. Bruce Schaefer, Toccoa	1954 Session
10—	H. L. Cheves, Union Point	1954 Session

Vice Councilors

<i>District</i>		<i>Term Expires</i>
1—	Charles T. Brown, Guyton	1955 Session
2—	Carl S. Pittman, Sr., Tifton	1955 Session
3—	Guy J. Dillard, Columbus	1955 Session
4—	Clarence B. Palmer, Covington	1955 Session
5—	J. G. McDaniel, Atlanta	1956 Session
6—	H. G. Weaver, Macon	1956 Session
7—	Ralph W. Fowler, Marietta	1956 Session
8—	James M. Hicks, Brunswick	1956 Session
9—	Charles R. Andrews, Jr., Canton	1954 Session
10—	J. Victor Roule, Augusta	1954 Session

Honorary Advisory Board

W. S. Goldsmith	President, 1915-1916
J. W. Palmer	President, 1918-1919
J. W. Daniel	President, 1923-1924
C. K. Sharp	President, 1928-1929
William R. Dancy	President, 1929-1930
M. M. Head	President, 1932-1933
C. H. Richardson	President, 1933-1934
Clarence L. Ayers	President, 1934-1935
B. H. Minchew	President, 1936-1937
Grady N. Coker	President, 1938-1939
J. C. Patterson	President, 1940-1941
Allen H. Bunce	President, 1941-1942
James A. Redfearn	President, 1942-1943
W. A. Selman	President, 1943-1944
Cleveland Thompson	President, 1944-1946
Ralph H. Chaney	President, 1946-1947
Enoch Callaway	President, 1949-1950
A. M. Phillips	President, 1950-1951
W. F. Reavis	President, 1951-1952
C. F. Holton	President, 1952-1953

MEMBERS OF THE HOUSE OF DELEGATES

A Preliminary Roster of the Legislative Body of the Medical Association of Georgia

Delegates to the 104th Annual Session of the Medical Association of Georgia are listed below.

Published in advance of the meeting, this list is subject to change.

ALTAMAHA

(Appling)

J. B. Brown, Jr., Baxley

BALDWIN

James Baugh, Milledgeville

Charles Fulghum, Milledgeville

BARTOW

Lewis Ross Whatley, Cartersville

BEN HILL - IRWIN

Francis O. Ward, Fitzgerald

BIBB

Henry H. Tift, Macon

J. B. Kay, Byron

Thomas L. Ross, Jr., Macon

Sam E. Patton, Macon

W. W. Baxley, Macon

BLUE RIDGE

C. C. Brooks, Blue Ridge

BROOKS

L. A. Smith, Quitman

BULLOCH-CANDLER-EVANS

John Mooney, Jr., Statesboro

BURKE

J. M. Byne, Jr., Waynesboro

CARROLL-DOUGLAS-HARALSON

Claude Van Sant, Douglasville

C. H. Allen, Bremen

GEORGIA MEDICAL SOCIETY

(Chatham)

T. A. Peterson, Savannah

John Elliott, Savannah

Ruskin King, Savannah

CHATTOOGA

W. U. Hyden, Trion

CHEROKEE-PICKENS

C. J. Roper, Jasper

CLARKE-MADISON-OCONEE

Marion A. Hubert, Athens

James A. Green, Athens

CLAYTON-FAYETTE

T. J. Bussey, Fayetteville

COBB

W. C. Mitchell, Smyrna

COFFEE

Sage Harper, Douglas

COLQUITT

A. G. Funderburke, Moultrie

COWETA

George W. Hammond, Newnan

CRISP

P. L. Williams, Sr., Cordele

DECATUR-SEMINOLE

E. M. Griffin, Bainbridge

DEKALB

W. A. Mendenhall, Chamblee

H. G. Carter, Decatur

DOOLY

O. W. Kitchens, Byromville

DOUGHERTY

W. M. Field, Albany

G. E. Seymour, Albany

ELBERT

D. M. Thompson, Elberton

EMANUEL

C. E. Powell, Swainsboro

FLOYD

Ralph Davis, Rome

Emmett Brannon, Rome

FORSYTH

Marcus Mashburn, Sr., Cumming

FRANKLIN

S. D. Brown, Jr., Royston

FULTON

John W. Turner, B. L. Shackelford, Hugh Hailey, Tully T. Blacklock, William G. Hamm, McClaren Johnson, Carter Smith, Harold P. McDonald, Ralph Huie, Allen H. Bunce, E. B. Agnor, J. H. Hilsman, B. T. Beasley, A. M. Collinsworth, James H. Byram, A. G. Linch, Duncan Shepard, A. A. Rayle, Jr., C. C. Aven, T. F. Davenport, Ben S. Read, Jack C. Norris, Sterling Claiborne, C. W. Strickler, A. A. Rayle, Sr., W. S. Dorrough, B. M. Chambers, W. H. Hill, Atlanta.

GLYNN

Robert Critchton, St. Simons Island

GORDON

Lewis R. Lang, Calhoun

GRADY

J. V. Rogers, Cairo

GWINNETT

D. C. Kelley, Lawrenceville

HABERSHAM

Joe J. Arrendale, Cornelia

HALL

W. C. McCarver, Jr., Gainesville

Rafe Banks, Jr., Gainesville

HANCOCK

C. S. Jernigan, Sparta

HART

J. Hubert Milford, Hartwell

JACKSON-BARROW

Alex B. Russell, Winder

JASPER

M. L. Green, Monticello

JEFFERSON

Walter J. Revell, Louisville

JENKINS

A. P. Mulkey, Millen

LAMAR

S. B. Taylor, Barnesville

LAURENS

Fred J. Coleman, Dublin

MACON

J. Fred Adams, Montezuma

McDUFFIE

Albert G. LeRoy, Thomson

MERIWETHER-HARRIS

Robert L. Bennett, Warm Springs

MITCHELL

J. C. Brim, Pelham

MONTGOMERY

Morris Kusnitz, Alamo

MORGAN

W. C. McGeary, Jr., Madison

MUSCOGEE

A. B. Conger, Jr., Elisha Cain, George M. Hutto, Frank B. Schley, all of Columbus

NEWTON

Clarence B. Palmer, Covington

OCMULGEE

M. F. Arnold, Hawkinsville

POLK

R. F. Spanjer, Cedartown

RABUN

George H. Boyd, Jr., Clayton

RANDOLPH-TERRELL

Robert B. Martin, Cuthbert

RICHMOND

R. C. McGahee, J. M. Martin,

C. M. Mulherin, T. W. Goodwin,

D. R. Thomas, Jr., G. W. Wright,

Augusta

SCREVEN

G. B. Hogsette, Sylvania

SOUTH GEORGIA

A. G. Little, Valdosta

F. G. Eldridge, Valdosta

SPALDING

Virgil Williams, Griffin

Alex P. Jones, Griffin

STEPHENS

C. L. Ayers, Toccoa

SUMTER

H. A. Smith, Americus

TATNALL

A. G. Pinkeston, Jr., Glennville

TAYLOR

E. C. Whatley, Reynolds

TELFAIR

F. R. Mann, McRae

THOMAS

George R. Dillinger, Thomasville

Kirk Shepard, Thomasville

TIFT

R. E. Jones, Tifton

TOOMBS

W. W. Aiken, Lyons

TRI-COUNTY

(Calhoun-Early-Miller)

J. H. Crowdis, Blakely

TROUP

Charles T. Cowart, LaGrange

H. H. Hammett, Jr., LaGrange

UPSON

T. A. Sappington, Thomaston

WALKER-CATOOSA-DADE

F. H. Simonton, Chickamauga

R. L. Patterson, Chattanooga

WALTON

Charles S. Floyd, Loganville

WARE

W. L. Pomeroy, Waycross

Leo Smith, Waycross

WARREN

H. B. Cason, Warrenton

WASHINGTON

William Rawlings, Sandersville

WAYNE

R. A. Pumpelly, Jesup

WHITFIELD

Earl McGhee, Dalton

WILKES

C. E. Willis, Jr., Washington

WORTH

Norman J. Crowe, Sylvester

MAG STANDING COMMITTEES, 1953-54

(One member appointed annually to serve for 3 years)

Scientific Work

H. Ansley Seaman, *Chairman*, Waycross (1953-54)
Charles H. Prince, Savannah (1953-55)
Fred H. Simonton, Chickamauga (1953-56)

Legislation

Carl C. Aven, *Chairman*, Atlanta (1953-55)
Jack C. Norris, Atlanta (1953-54)
Joseph D. McElroy, Atlanta (1953-56)

Subcommittee on Legislation

Grady N. Coker, Canton	Virgil B. Williams, Griffin
T. F. Sellers, Atlanta	Tully T. Blalock, Atlanta
Marcus Mashburn, Sr., Cumming	James C. Brim, Pelham
T. A. Peterson, Savannah	F. Kells Boland, Jr., Atlanta
Alexander B. Russell, Winder	J. Harry Rogers, Atlanta
	Sam Garner, Rome
	Milford B. Hatcher, Macon

District County Society Subcommittee on Legislation

George Kinnard, Newnan (Fourth)
W. K. Philpot, Augusta (Tenth)
J. T. Holt, Baxley (Appling)
Wallace Gibson, Milledgeville (Baldwin)
A. L. Horton, Cartersville (Bartow)
W. P. Coffee, Fitzgerald (Ben Hill-Irwin)
L. C. May, Blue Ridge (Blue Ridge)
A. B. Jones, Jr., Quitman (Brooks)
Louie H. Griffin, Claxton (Bulloch-Candler-Evans)
J. M. Byne, Jr., Waynesboro (Burke)
R. E. Hamilton, Douglasville (Carroll-Douglas-Haralson)
L. O. Wootten, Cordele (Crisp)
Paul T. Russell, Albany (Dougherty)
J. B. O'Neal, Elberton (Elbert)
Tom Harbin, Rome (Floyd)
Carl C. Aven, Atlanta (Fulton)
R. D. Walter, Calhoun (Gordon)
D. C. Kelley, Lawrenceville (Gwinnett)
J. J. Arrendale, Cornelia (Habersham)
C. G. Butler, Gainesville (Hall)
F. S. Belcher, Monticello (Jasper)
Q. A. Mulkey, Millen (Jenkins)
A. T. Coleman, Dublin (Laurens)
James Johnson, Manchester (Meriwether-Harris)
E. M. Walker, Pelham (Mitchell)
Roy L. Gibson, Columbus (Muscogee)
R. M. Paty, Covington (Newton)
A. S. Marshall, Ft. Valley (Peach-Houston)
David R. Thomas, Jr., Augusta (Richmond)
B. G. Owens, Valdosta (South Georgia)
Virgil Williams, Griffin (Spalding)
R. C. Pendergrass, Americus (Sumter)
R. C. Montgomery, Butler (Taylor)
F. R. Mann, Sr., McRae (Telfair)
William McCollum, Thomasville (Thomas)
Fred H. Simonton, Chickamauga (Walker-Catoosa-Dade)
H. B. Nunnally, Monroe (Walton)
H. T. Atkins, Waycross (Ware)
Trammell Starr, Dalton (Whitfield)

Medical Education

R. Hugh Wood, *Chairman*, Emory University (1953-56)
E. R. Pund, Augusta (1953-55)
C. H. Richardson, Sr., Macon (1953-54)

Medical Defense

Marion C. Pruitt, *Chairman*, Atlanta (1953-58)
H. L. Cheves, Union Point David Henry Poer, Atlanta

Professional Conduct

Ralph Chaney, *Chairman*, Augusta
Enoch Callaway, LaGrange W. F. Reavis, Waycross
A. M. Phillips, Macon C. F. Holton, Savannah

History and Vital Statistics

J. Calvin Weaver, *Chairman*, Atlanta (1953-56)
H. L. Erwin, Dalton (1953-55)
Frank K. Boland, Atlanta (1953-54) *

*Deceased

Public Health

T. A. Sappington, *Chairman*, Thomaston (1953-56)
B. H. Hand, LaGrange (1953-54)
Wilbur D. Hall, Calhoun (1953-55)

District County Society Subcommittee on Public Health

Evan W. Molyneux, Hogansville (Fourth)
J. B. Neighbors, Athens (Tenth)
J. T. Holt, Baxley (Appling)
Wallace Gibson, Milledgeville (Baldwin)
A. L. Horton, Cartersville (Bartow)
J. E. McMillan, Fitzgerald (Ben Hill-Irwin)
C. C. Brooks, Blue Ridge (Blue Ridge)
L. A. Smith, Quitman (Brooks)
Helen R. Deal, Statesboro (Bulloch-Candler-Evans)
J. M. Byne, Jr., Waynesboro (Burke)
F. W. Morgan, Douglasville (Carroll-Douglas-Haralson)
O. T. Gower, Jr., Cordele (Crisp)
W. P. Rhyne, Albany (Dougherty)
R. F. Norton, Rome (Floyd)
L. M. Blackford, Atlanta (Fulton)
Byron H. Steele, Fairmount (Gordon)
Sylvester Cain, Norcross (Gwinnett)
F. O. Garrison, Demorest (Habersham)
Ed. W. Grove, Gainesville (Hall)
F. S. Belcher, Monticello (Jasper)
H. G. Lee, Millen (Jenkins)
O. H. Cheek, Dublin (Laurens)
W. P. Allen, Woodbury (Meriwether-Harris)
J. C. Brim, Pelham (Mitchell)
R. L. Gibson, Columbus (Muscogee)
C. B. Palmer, Covington (Newton)
A. S. Marshall, Ft. Valley (Peach-Houston)
A. J. Davis, Augusta (Richmond)
J. Gregg Smith, Valdosta (South Georgia)
James R. Thomas, Griffin (Spalding)
Russell Thomas, Americus (Sumter)
R. C. Montgomery, Butler (Taylor)
C. J. Maloy, McRae (Telfair)
Charles Watt, Jr., Thomasville (Thomas)
Fred H. Simonton, Chickamauga (Walker-Catoosa-Dade)
Ernest Thompson, Monroe (Walton)
J. F. Hooker, Waycross (Ware)
H. L. Erwin, Dalton (Whitfield)

Maternal Welfare

Peter Hydrick, *Chairman*, College Park
E. D. Colvin, *Vice-Chairman*, Atlanta
C. M. Mulherin, Augusta Fred H. Simonton,
Helen W. Bellhouse, Atlanta Chickamauga
Howard J. Morrison, A. B. Daniel, Statesboro
Savannah

Rural Health

W. W. Turner, *Chairman*, Nashville
T. F. Sellers, *Ex-officio*, Atlanta

Districts

1—Charles T. Brown, Guyton
2—H. B. Jenkins, Donalsonville
3—Frank Vinson, Ft. Valley
4—Clarence B. Palmer,
Covington
5—Sterling H. Jernigan, Atlanta

Districts

6—E. B. Claxton, Dublin
7—B. H. Steele, Fairmount
8—W. W. Turner, Nashville
9—Joe Arrendale, Cornelia
10—Lynn M. Huie, Monroe

Industrial Health

Duncan Shepard, *Chairman*, Atlanta
Charles S. Jones, *Vice-Chairman*, Atlanta
John G. Sharpley, Savannah George R. Conner, Columbus
Robert M. Harbin, Jr., Rome W. Bruce Schaefer, Toccoa
A. G. Little, Jr., Valdosta L. M. Petrie, Ex-officio, Atlanta
Charles L. Ridley, Jr., Macon

Public Relations

Chris J. McLoughlin, *Chairman*, Atlanta
Peter L. Scardino, Savannah Eugene Ward, Gainesville
Thomas L. Ross, Jr., Macon Warren M. Gilbert, Rome
J. Lamont Henry, Atlanta W. C. Cook, Columbus
J. L. Chandler, Jr., Augusta Geo. R. Dillinger, Thomasville

Cancer

J. E. Scarborough, *Chairman*, Atlanta*
Hoke Wammock, Augusta*
David Henry Poer, Atlanta*
R. C. Pendergrass, Americus*
Enoch Callaway, LaGrange*
W. F. Jenkins, Columbus
John Funke, Atlanta
John L. Barner, Athens
F. D. Eldridge, Valdosta
Lester Harbin, Rome
*Executive committee

Everett L. Bishop, Atlanta*
Thomas Harold, Macon*
Lee Howard, Savannah
Neal F. Yeomans, Waycross
Kirk Shepard, Thomasville
Major F. Fowler, Atlanta
Wadley R. Glenn, Atlanta
A. H. Letton, Atlanta

Insurance Board

John L. Elliott, *Chairman*, Savannah
Mr. H. B. Coolidge, *Secretary*, Savannah

Districts

1—John L. Elliott, Savannah
2—J. Z. McDaniel, Albany*
3—L. H. Wolff, Columbus
4—J. M. Kellum, Thomaston
5—O. E. Hanes, Atlanta*
*Resigned

Districts

6—A. M. Phillips, Macon
7—D. L. Wood, Dalton
8—W. L. Pomeroy, Waycross
9—G. T. Nicholson, Cornelia
10—David R. Thomas, Jr., Augusta

SPECIAL COMMITTEES

(Appointed annually)

Woman's Auxiliary

Ralph H. Chaney, *Chairman*, Augusta
Enoch Callaway, LaGrange
A. M. Phillips, Macon

W. F. Reavis, Waycross
C. F. Holton, Savannah

Awards

Mark S. Dougherty, Jr., *Chairman*, Atlanta
Hoke Wammock, *Co-Chairman*, Augusta
W. E. Storey, Columbus

Constitution and By-Laws

Allen H. Bunce, *Chairman*, Atlanta
J. W. Chambers, *Co-Chairman*, LaGrange
H. D. Allen, Milledgeville
Enoch Callaway, LaGrange

Peter B. Wright, Augusta

American Medical Education Foundation

E. Van Buren, *Chairman*, Atlanta
C. F. Holton, Savannah
C. H. Richardson, Jr., Macon
James S. Holder, LaGrange
Ernest F. Wahl, Thomasville

Sage Harper, Douglas
Ralph N. Johnson, Rome
J. Hubert Milford, Hartwell

Blood Banks

J. C. Thoroughman, *Chairman*, Atlanta
Lee Howard, Jr., Savannah
Warren B. Matthews, Atlanta

D. F. Mullins, Jr., Augusta
Frederick H. Thompson, Atlanta

Abner Wellborn Calhoun Lectureship

Glennville Giddings, *Chairman*, Atlanta
James H. Semans, Atlanta*
Henry H. Tift, Macon
*Resigned

Edward L. Bosworth, Rome

Medical Civil Preparedness

Edgar M. Dunstan, *Chairman*, Atlanta
C. A. Eberhart, Atlanta
J. S. Skobba, Atlanta
Charles Dowman, Atlanta

T. J. Ferrell, Waycross
Lee H. Battle, Jr., Rome

Veterans' Affairs

Hartwell Joiner, *Chairman*, Gainesville
A. R. Bush, Dublin
A. O. Colquitt, Jr., Marietta
Bernard P. Wolff, Atlanta

L. M. Freedman, Savannah
C. C. Butler, Columbus

Hospitals

R. F. Spanjer, *Chairman*, Cedartown
Hugh J. Bickerstaff, Columbus
A. J. Davis, Augusta
H. A. Goodwin, Summerville
W. D. Hazlehurst, Macon
J. H. Hooker, Waycross
Rafe Banks, Gainesville
E. M. Lancaster, Shady Dale

J. C. Patterson, Cuthbert
H. D. Tyler, Thomaston
Ernest Thompson, Monroe
H. E. Weems, Perry
L. C. Yeargin, Dalton
W. B. Fackler, Jr., LaGrange

Chronic Illness

L. M. Blackford, *Chairman*, Atlanta
E. F. Wahl, Thomasville
W. L. Pomeroy, Waycross
H. H. Turner, Columbus

Harry T. Harper, Jr., Augusta
J. B. Neighbors, Jr., Athens

Mental Health

J. R. Shannon Mays, *Chairman*, Macon
Paul Schroeder, Atlanta
T. G. Peacock, Milledgeville
Guy Rice, Atlanta

R. D. Walters, Calhoun
Gibson K. Cornwell, Fitzgerald

Crawford W. Long Memorial

Lester Rumble, Jr., *Chairman*, Atlanta
Augustus B. Boyd, Athens
Perry Volpitto, Augusta

Liaison Advisory Board to the Georgia Society For Crippled Children

H. Walker Jernigan, Atlanta
J. C. Hughston, Columbus
P. A. Mulherin, Augusta

Ruth M. Waring, Savannah
Ralph W. Fowler, Marietta

Medical Advisory to Selective Service System

A. O. Lynch, *Chairman*, Atlanta
Cyrus W. Strickler, Jr., *Co-Chairman*, Atlanta
David Henry Poer, Atlanta
Carter Smith, Atlanta
T. F. Sellers, Atlanta
L. Minor Blackford, Atlanta

W. G. Hamm, Atlanta
S. A. Garrett, D.D.S., Atlanta
Charles C. Rife, D.V.M., Atlanta

Fraternal Delegates to Adjoining States

ALABAMA: Oliver W. Jenkins, Lindale, and D. S. Reese, Carrollton
FLORIDA: J. W. Chambers, LaGrange, and R. M. Joiner, Moultrie
SOUTH CAROLINA: Howard J. Morrison, Savannah, and R. C. McGahee, Augusta
TENNESSEE: William R. Dancy, Savannah, and R. N. Little, Summerville

State Board of Health

First District: James M. Byne, Jr., Waynesboro, Sept. 1, 1957; Second District: A. G. Funderburk, Moultrie, Sept. 1, 1957; Third District: R. C. Montgomery, Butler, Sept. 1, 1954; Fourth District: M. M. Head, Zebulon, Sept. 1, 1955; Fifth District: Spencer A. Kirkland, Atlanta, Sept. 1, 1954; Sixth District: A. M. Phillips, Macon, Sept. 1, 1956; Seventh District: Fred H. Simonton, Chickamauga, Sept. 1, 1956; Eighth District: C. J. Malloy, McRae, Sept. 1, 1956; Ninth District: R. Lee Rogers, Gainesville, Sept. 1, 1956; Tenth District: Thos. W. Goodwin, Augusta, Sept. 1, 1955; *Georgia Dental Association*—J. M. Hawley, Columbus, Sept. 1, 1958, J. G. Williams, Atlanta, Sept. 1, 1958; *Georgia Pharmaceutical Association*—Preston Summer, East Point, Sept. 1, 1953; A. T. McRae, Douglas, Sept. 1, 1956.

State Board of Medical Examiners

Fred J. Coleman, Dublin; J. W. Palmer, Ailey; C. K. Wall, Thomasville; Grady N. Coker, Canton; R. H. McDonald, Newnan; A. M. Deal, Statesboro; Alexander B. Russell, Chairman, Winder; Rufus A. Askew, Atlanta; W. H. Powell, Hazlehurst.

Advisory Board to Clarke-Oconee County Survey

Mark S. Dougherty, Jr., *Chairman*, Atlanta
Walker Jernigan, Atlanta
George R. Dillinger, Thomasville

State Medical Education Board

C. L. Howard, *Chairman*, Pelham
J. W. Mauldin, *Vice-Chairman*, Alma
W. P. Harbin, Rome
J. Hubert Milford, Hartwell
C. F. Holton, Savannah

DISTRICT OFFICERS

First District

Samuel F. Rosen, Savannah, *President*
William H. Fulmer, Savannah, *Secretary*

Second District

Phil E. Roberson, Albany, *President*
Frank A. Little, Thomasville, *Secretary*

Third District

John H. Robinson III, Americus, *President*
T. Schley Gatewood, Americus, *Secretary*

Fourth District

J. M. Kellum, Thomaston, *President*
George Kinnard, Newnan, *Secretary*

Fifth District

W. S. Dorough, Atlanta, *President*
C. Purcell Roberts, *Secretary*

Sixth District

William Rawlings, Sandersville, *President*
C. H. Richardson, Jr., Macon, *Secretary*

Seventh District

H. L. Erwin, Dalton, *President*
Ralph N. Johnson, Rome, *Secretary*

Eighth District

Henry T. Adkins, Waycross, *President*
Sage Harper, Douglas, *Secretary*

Ninth District

E. L. Ward, Gainesville, *President*
George T. Nicholson, Cornelia, *Secretary*

Tenth District

Bothwell Traylor, Athens, *President*
Donald W. Schmidt, Lincolnton, *Secretary*

SECTION OFFICERS

Georgia Chapter

American College of Surgeons

Charles Watt, Thomasville, *President*
Duncan Shepard, Atlanta, *Secretary*
Charles S. Jones, Atlanta, *Program Chairman*

Georgia Radiological Society

Stephen W. Brown, Augusta, *President*
Robert M. Tankesley, Atlanta, *Secretary*
and *Program Chairman*

Georgia Association of Pathologists

Lee Howard, Savannah, *President*
Darrell Ayer, Atlanta, *Secretary*
and *Program Chairman*

Georgia Society of Ophthalmology and Otolaryngology

J. Kirk Train, Savannah, *President*
Alton V. Hallum, Atlanta, *Secretary*
and *Program Chairman*

Georgia Academy of General Practice

H. L. Cheves, Union Point, *President*
Maurice F. Arnold, Hawkinsville, *Secretary*
Peter Hydrick, College, Park, *Program Chairman*

Georgia Society of Anesthesiologists

C. M. Westerfield, Savannah, *President*
A. J. Waters, Augusta, *Secretary*
and *Program Chairman*

Georgia Chapter

American College of Physicians

Carter Smith, Atlanta, *Governor*
Mark S. Dougherty, Jr., Atlanta, *Program Chairman*

Georgia Heart Association

Joseph Massee, Atlanta, *President*
Lamont Henry, Atlanta, *Secretary*
Sterling Claiborne, Atlanta, *Program Chairman*

Georgia Chapter

American College of Chest Physicians

John Elliott, Savannah, *President*
Clarence Mills, Atlanta, *Secretary*
Bernard Wolff, Atlanta, *Program Chairman*

Georgia Urological Society

J. Robert Rinker, Augusta, *President*
J. Z. McDaniel, Albany, *Secretary*

Georgia Pediatrics Society

Harold W. Muecke, Waycross, *President*
J. Harry Lange, Atlanta, *Secretary*
Joseph Yampolsky, Atlanta, *Program Chairman*

Georgia Orthopedic Society

Fred G. Hodgson, Atlanta, *President*
C. G. Henry, Augusta, *Secretary*
Thomas P. Waring, Savannah, *Program Chairman*

Georgia State Obstetrical and Gynecological Society

Hugh Bickerstaff, Columbus, *President*
Eugene Griffin, Atlanta, *Secretary*
W. K. Jordan, Macon, *Program Chairman*

Georgia Trudeau Society

H. E. Crow, Rome, *President*
Sam E. Patton, Macon, *Secretary*

Georgia Industrial Surgeons Association

W. W. Battey, Augusta, *President*
A. M. Collinworth, Atlanta, *Secretary*
J. C. Read, Atlanta, *Program Chairman*

INFORMATION

Alumni Dinner Meetings

Alumni Dinners will be held at 7:30 Monday evening as follows: Emory University School of Medicine, Edmund A. Brannen, Chairman, Pinebrook Inn, Route 41, Forsyth Road; Medical College of Georgia, William L. Barton, Chairman, Walter Little Room, Dempsey Hotel and Tulane University of Louisiana School of Medicine, Henry H. Tift, Chairman, Jeff Davis Room, Lanier Hotel, 555 Mulberry Street.

Council Meetings

Registration of Councilors will be held at 10 a.m. Sunday on the Mezzanine floor, Dempsey Hotel. Final meeting of the 1953-54 Council will be held at 10:30 a.m. in the A & B Room, Hotel Dempsey. Council Luncheon in honor of Past Presidents will be held at 12:30 p.m. Sunday in the Pine Room, Dempsey Hotel. The 1953-54 Council will hold an organizational meeting at 3:30 Wednesday in the Walter Little Room, Dempsey Hotel.

THE 104th ANNUAL

SUNDAY - MAY 2

- 1:00 P.M. **REGISTRATION OF DELEGATES**
East Corridor, Main Floor, Auditorium
- 2:00 P.M. **MEETING, HOUSE OF DELEGATES**
Main Floor, Auditorium
- 2:00 P.M. **GEORGIA RADIOLOGICAL SOCIETY**
Blue Flame Room, Macon Natural Gas Bldg.
- 3:00 P.M. **GEORGIA SOCIETY OF ANESTHESIOLOGISTS**
Mirror Room, Hotel Dempsey
- 3:00 P.M. **GENERAL REGISTRATION**
East Corridor, Main Floor, Auditorium
- 4:30 P.M. **JOINT MEMORIAL SERVICE**
Main Floor, Auditorium

MONDAY - MAY 3

- 8:15 A.M. **SECTION MEETINGS**
- RADIOLOGY**
Blue Flame Room, Macon Natural Gas Bldg.
- UROLOGY**
Main Floor, Auditorium
- ANESTHESIOLOGY**
Kilowatt Room, Ga. Power Co. Bldg.
- PEDIATRICS AND ORTHOPEDICS**
Civic Room, Downstairs, Auditorium
- 10:45 A.M. **GENERAL SESSION**
President's Address and Nomination of Officers
Main Floor, Auditorium
- 1:00 P.M. **SPECIALTY SOCIETY LUNCHEONS**
- 2:15 P.M. **GENERAL CLINICAL SESSION**
Main Floor, Auditorium
- 7:30 P.M. **ALUMNI DINNERS**

SESSION TIMETABLE

TUESDAY - MAY 4

8:15 A.M.	SECTION MEETINGS GENERAL PRACTICE AND EENT <i>Main Floor, Auditorium</i> INDUSTRIAL SURGERY AND MEDICINE <i>National Guard Room, Down- stairs, Auditorium</i> INTERNAL MEDICINE <i>Civic Room, Downstairs, Audi- torium</i> OBSTETRICS AND GYNECOLOGY <i>Kilowatt Room, Ga. Power Co. Bldg.</i> PATHOLOGY <i>Blue Flame Room, Macon Nat- ural Gas Bldg.</i>
10:50 A.M.	JOINT SESSIONS INTERNAL MEDICINE, THORACIC DISEASES AND GENERAL PRACTICE <i>Main Floor, Auditorium</i> PATHOLOGY AND OBSTETRICS AND GYNECOLOGY <i>Kilowatt Room, Ga. Power Co. Bldg.</i>
1:00 P.M.	SPECIALTY SOCIETY LUNCHEONS
2:00 P.M.	HOUSE OF DELEGATES <i>Civic Room, Downstairs, Audi- torium</i>

WEDNESDAY - MAY 5

8:25 A.M.	SECTION MEETINGS SURGERY AND THORACIC DISEASES <i>Main Floor, Auditorium</i> INTERNAL MEDICINE <i>Civic Room, Downstairs, Audi- torium</i>
11:30 A.M.	JOINT SESSION ON MEDICINE AND SURGERY <i>Main Floor, Auditorium</i>
2:30 P.M.	FINAL SESSION HOUSE OF DELEGATES <i>Walter Little Room, Dempsey Hotel</i>
2:35 P.M.	FINAL GENERAL SESSION <i>Walter Little Room, Dempsey Hotel</i>
3:30 P.M.	NEW COUNCIL ORGANIZATIONAL MEETING <i>Walter Little Room, Dempsey Hotel</i>
3:30 P.M.	1955 ANNUAL SESSION PROGRAM COMMITTEE CHAIRMEN MEETING <i>Walter Little Room, Dempsey Hotel</i>

INFORMATION

Registration

The official registration desk, located in the East Corridor, Main Floor, Auditorium, will be open for Registration of MAG members and guests at 3 p.m. Sunday and at 8:15 a.m. on Monday, Tuesday and Wednesday. Members, medical visitors and guests should register there *immediately upon arrival* in the city and obtain badges and programs.

Badges will be required for attendance at any meeting or for admission to the exhibit area.

All phone calls, telegrams or mail should be handled through the Medical Association of Georgia, Macon City Auditorium, during the period of the Annual Session.

Official Bulletin Board

All notices of an official nature will be posted on the Association Bulletin Board adjoining the Registration Desk. Voting rules will be posted on this Board at all times.

Headquarters Suite

For special committee meetings and necessary conferences, a Headquarters office suite will be maintained in the Dempsey Hotel throughout the Annual Session, key for which may be obtained from the Secretary or Executive Secretary.

House of Delegates

The House of Delegates will meet Sunday, May 2, at 2 p.m. in the Main Floor, Auditorium; at 2 p.m. Tuesday, Civic Room, Downstairs Auditorium and at 2:30 p.m. Wednesday, Walter Little Room, Dempsey Hotel.

Tickets

Tickets will be available for the Sunday Buffet Supper, Dempsey Hotel, the President's Dinner Tuesday at the Idle Hour Country Club and for the Special Guests Luncheon Wednesday at the Dempsey Hotel. Wives are most cordially invited to attend these events, dress optional.

Tickets should be purchased at the time of registration. Eating facilities at all places are limited. The Local Arrangements Committee cannot be responsible unless each member cooperates in this manner.

Only enough tickets will be available to conform with seating limits. This is your official notice—please be governed accordingly.

Joint Memorial Service

The Joint Memorial Service, co-sponsored by the Woman's Auxiliary, will be held at 4:30 p.m. Sunday on the Main Floor, Auditorium. Deceased members of both organizations will be honored at this time.

President's Dinner

The President's Dinner will be held Tuesday evening at 7 p.m. at the Idle Hour Country Club, Forsyth Rd., Route 41. The Dinner will be preceded by a Social Hour, compliments of the Central of Georgia Railway Company.

Election of Officers

Nominations for the election of MAG officers will be made at the General Session on the Main Floor, Auditorium at 12:30 p.m. Monday. In addition to the regular officers to be elected, members must elect two A.M.A. delegates and two alternates. The Association now has three delegates due to increased membership. The location of the ballot box will be posted on the official bulletin board and voting rules will also be posted on the bulletin board and on the ballots. The ballot box will be open Monday from 2 p.m. to 5 p.m., on Tuesday from 9 a.m. to 5 p.m. and Wednesday from 9 a.m. to 10:30 a.m.

Woman's Auxiliary

The Woman's Auxiliary will have its headquarters in the Dempsey Hotel. Auxiliary members will register from 11 a.m. to 6 p.m. Sunday, from 9 a.m. to 4:30 p.m. Monday and from 9 a.m. to 1 p.m. Tuesday on the Mezzanine, Hotel Dempsey.

Golf Tournament

The Association Golf Tournament will be held Sunday, Monday and Tuesday afternoons at the Idle Hour Country Club. Members can obtain detail information from Mr. Bob Hayes, Club Professional, concerning the tournament. Score cards must be turned in to Mrs. Hayes. Handicaps will be established by the Professional.

Specialty Society Luncheons

The following specialty societies will sponsor luncheons at 1 p.m. Monday, May 3: Georgia Pediatric Society at the Macon Elks Club, 841 Mulberry Street, William C. Boswell, Chairman; Georgia Urological Society, Pine Room, Dempsey Hotel, Willard R. Golsan, Chairman; Georgia Radiological Society, Mirror Room, Dempsey Hotel, Herbert M. Olnick, chairman.

Tuesday Luncheons include: Georgia Society of Ophthalmology and Otolaryngology, at 1 p.m. at the Pine Room, Dempsey Hotel, William L. Barton, Chairman; Georgia Academy of General Practice at 1 p.m. at the Mirror Room, Dempsey Hotel, Frank M. Houser, Chairman; Georgia Chapter, American College of Surgeons at 1 p.m. at the Jeff Davis Room, Lanier Hotel, 555 Mulberry St.; Sam E. Patton, Chairman; Georgia Association of Pathologists, S & S Cafeteria, 337 Third Street, Max Mass, Chairman.

The Georgia State Obstetrical and Gynecological Society will meet at 2 p.m. Tuesday at the Elks Club, 841 Mulberry Street. Jule C. Neal is chairman.

Technical Exhibits

It is very important that you register at the exhibits which are on display in the entrance corridor and main floor of the auditorium. These exhibitors are actively supporting YOUR Annual Session and their displays are arranged for your visit.

Scientific Exhibits

The Scientific Exhibits are displayed in the entrance corridor facing the technical exhibits. All members are urged to visit these exhibits.

GUEST SPEAKERS
104TH ANNUAL SESSION
MEDICAL ASSOCIATION OF GEORGIA

Asst. Secretary of Defense

Frank Brown Berry, Assistant Secretary of Defense and Professor of Clinical Surgery, Columbia University, will address the joint section on Surgery and Thoracic Diseases, Wednesday, on the topic "Importance of the Ordinary Chest Film in the Diagnosis of Malignant Tumors of the Lungs."

Dr. Berry is a fellow of the American College of Surgeons, diplomate and founder-member of the American Board of Surgery and the Board of Thoracic Surgery. He has practiced surgery in New York City from 1924 to the present and also served in the Medical Corps in both World Wars. A summary of his paper follows:

The topic of the talk is the "Importance of the Ordinary Chest Film in the Diagnosis of Malignant Tumors of the Lungs". It is the earliest and most important evidence of pulmonary disease and is available to all practicing physicians, general practitioners and specialists alike. The value of comparative films is pointed out; also the comparison of the results of x-rays with bronchoscopies and cytological examinations either of bronchial secretions or sputum. Many different types of identical shadows will be seen in the films and the importance of either a positive or negative decision as to surgery, together with a proper period of observation prior to surgery, is emphasized. The surgery itself is then discussed, again with the decision as to simple expiration, palliation or removal. In connection with the above slides, the whole problem of bronchogenic carcinoma is emphasized in the light of our present conception of the disease, the treatment, both radical and palliative, by surgery, radiotherapy or chemotherapy, as may be indicated.



Frank Brown Berry, M.D.

To Talk on Diabetes Mellitus

Arthur R. Colwell, Chairman, Department of Medicine, Northwestern University Medical School and author of textbooks on diabetes mellitus, who received his M.D. degree from Rush Medical College, will address the Section on Medicine and Surgery on Wednesday May 5. A summary of his address, "Selective Treatment of Diabetes Mellitus According to Severity", follows:



Arthur R. Colwell, M.D.

In its various stages of severity diabetes mellitus represents a loss of more or less of the normal homeostatic ability to regulate the utilization of sugar and other metabolic functions which are dependent upon it. As more and more loss occurs, diabetes of greater and greater severity becomes manifest and more and more skill is required to maintain nutrition and preserve a normal balance between food and insulin.

The chief problem in asymptomatic diabetes with nearly normal sugar tolerance is its diagnosis and differentiation from harmless metabolic anomalies. Treatment is easy by diet restriction. More severe forms of the disease require depot insulin therapy, of course, in addition to regulation of the food intake. Selection of appropriate depot insulins to fit individual needs depends chiefly upon knowledge of their timing characteristics, appraisal of the severity of diabetes in the individual case, and careful study of behavior at all times of day and night. Labile forms of diabetes and emergencies require special techniques.

Surgery Speaker



Oscar Creech, Jr., M.D.

Oscar Creech, Jr., Assistant Professor of Surgery, Baylor University College of Medicine, Houston, Texas, will address the joint section on Surgery and Thoracic Diseases Wednesday, on "Coin Lesions of the Lung" and the joint section on Medicine and Surgery, Wednesday, on "Surgical Treatment of Aneurysms and Thrombo-obliterative Disease of the Aorta".

He received his M.D. degree from Jefferson Medical College. A summary of his paper on aneurysms follows:

Aneurysms and thrombo-obliterative disease of the aorta constitute two of the most common and serious forms of aortic disease. Both conditions are associated with a poor prognosis. Pressure symptoms and rupture and hemorrhage are common complications of aneurysm, and progressive arterial insufficiency, ischemia and gangrene are complications of thrombotic occlusion. The treatment of these lesions has been generally unsatisfactory until recently. During the past few years efforts have been directed toward a more effective form of therapy consisting of removal of the lesion and restoration of function by aortic repair or by insertion of aortic homograft. Although this form of therapy cannot be applied in all cases, it remains the treatment of choice.

Syphilitic aneurysms of the thoracic aorta are generally sacular and are best treated by excision and lateral repair of the aortic wall. Arteriosclerotic aneurysms of the descending thoracic aorta are generally fusiform and are treated by resection and replacement with a homograft. Aneurysms of the abdominal aorta are almost always arteriosclerotic in origin and generally occur below the renal arteries. Thrombo-obliterative disease of the aorta also occurs characteristically in the abdominal aorta in the region of the bifurcation. Both aneurysms and thrombotic occlusive disease are treated by resection of the involved segment which generally includes the bifurcation of the aorta and replacement with a homograft.

Pathology Speaker



Cyrus C. Erickson, M.D.

Cyrus C. Erickson, Associate Director, Institute of Pathology, University of Tennessee, Memphis, will speak on "Carcinoma in Situ," before the Section on Pathology at 8:30 a. m. Tuesday, May 4.

He will also take part in a panel discussion on "Carcinoma of the Female Genital Tract," before a Joint Session on Pathology and Obstetrics and Gynecology at 10:50 a.m. Tuesday. Dr. Erickson received his medical degree from the University of Minnesota Medical School. He is a member of the American Society of Pathology and Bacteriology, American Board of Pathology, American Society for Experimental Pathology. He was formerly Associate Professor of Pathology at the Duke University School of Medicine, Durham, N. C.

Orthopedic Speaker

C. E. Irwin, chief of orthopedic surgery at Georgia Warm Springs Foundation since 1936, will address the Joint Section on Pediatrics and Orthopedics Monday on the subject, "The Ilio-Tibial Band Syndrome."

A graduate of Emory University School of Medicine, Dr. Irwin is certified by the American Board of Orthopedic Surgeons and a member of the American Academy of Orthopedic Surgeons, American Orthopedic Association and the American Society for Surgery of the Hand. A summary of his paper follows:

This presentation is concerned with the narration of a motion picture of two patients before and after surgical rehabilitation. Both patients have severe and multiple deformities following unrecognized and uncorrected contractures of the iliotibial fascia. This contracted iliotibial fascia is one of the most common and yet most vicious and wide-spread deformities following an attack of poliomyelitis involving the lower extremities. These two patients clearly demonstrate almost complete disability in the presence of their multiple deformities. Sufficient importance has not been given this contracture. One must remember that it is the enveloping and intermuscular fascia that shortens and not the normal musculature that has escaped the disease.

Among the deformities that a patient can develop directly or indirectly are hip flexion and abduction contractures, either unilateral or bilateral, knock knee deformity, tibial torsion and varus deformity of the foot. They have severe lordosis with bilateral contractures and a fixed pelvic obliquity with an accompanying scoliosis with unilateral contracture. The deformities in the lower extremities make it



Charles E. Irwin, M.D.

difficult to accurately fit the necessary orthopedic appliances. Contracture of this fascia makes it impossible for these individuals to stand erect and properly distribute their weight for practical weight bearing. Some even must resort to quadriped locomotion.

The film shows all deformities in detail, the operative procedures to correct the contractures, methods of postoperative wedgings, immobilization and the final end result.

Internist to Speak

Edgar Hull, who will address the Section on Internal Medicine Tuesday on "Outlook in Patients with Myocardial Infarction", is at present Head of the Department of Medicine, Louisiana State University School of Medicine.



Edgar Hull, M.D.

From October 1950 to June 1951 Dr. Hull was Visiting Professor of Medicine at the University of Bologna, Italy

(Fulbright Grant), and in 1944 Dr. Hull received the Markle Fellowship for study of tropical diseases, Costa Rica and Guatemala. A graduate of Tulane University School of Medicine, he has served two terms as president of the Louisiana Heart Association. He is a member of the Board of Directors of the American Heart Association and a former president of the New Orleans Graduate Medical Assembly.

Radiology Guest Speaker

Edward B. D. Neuhauser, who will address the General Session on Monday morning on "Lesions of the Lower Esophagus as a Cause of Vomiting in Infants", is Radiologist-in-Chief on the Children's Hospital of Boston.

Dr. Neuhauser is also Assistant Clinical Professor of Radiology, Harvard Medical School; Roentgenologist, The Boston Lying-In Hospital, Boston; and Consultant in Radiology, Peter Bent Brigham Hospital, Boston.

The explanation for many causes of vomiting, particularly if associated with hematemesis or occult blood in the stools, is to be found in lesions of the lower esophagus. Relaxation of the lower esophagus, hiatus or para-esophageal hiatus hernia, peptic ulceration of the lower esophagus and several other conditions have as a common denominator reflux of gastric contents through a relaxed hiatus.

If the frequency and significance of these lesions is appreciated they can be satisfactorily delineated by roentgen means and proper medical or surgical therapy instituted.



E. B. D. Neuhauser, M.D.

A.M.A. President-Elect

Walter B. Martin, President-Elect of the American Medical Association, will address the House of Delegates Sunday on the "Legislative Activities of the AMA" and the General Session Monday on "Your AMA Is What You Make It".

Dr. Martin has served the American Medical Association as a member of the House of Delegates, the Council on Medical Service and the Board of Trustees. He is a member of the Coordinating Committee which is directing the national educational campaign against socialized medicine.

Dr. Martin, who received his M.D. degree from Johns Hopkins University School of Medicine, is chief of the medical service at the Hospital of St. Vincent De Paul in Norfolk, Virginia, where he began his practice of internal medicine in 1919. Dr. Martin served in the Army Medical Corps during both World War I and II. He is a past president of the Seaboard Medical Association, the Medical Society of Virginia and the Norfolk County Medical Society.



Walter B. Martin, M.D.

Anesthesiology Speaker



Alice McNeal, M.D.

Alice McNeal, Director of the Department of Anesthesiology, Medical College of Alabama, Birmingham, will address the Section on Anesthesiology on Monday on "Coma Due to Drug Overdosage".

Dr. McNeal received her M.D. degree from Rush Medical College and was on the Anesthesia staff of Presbyterian Hospital, Chicago, before coming to

the Medical College of Alabama.

A summary of Dr. McNeal's paper follows:

Management of the comatose patient whose condition is caused by ingestion of depressant drugs.

If the patient can be aroused, response to painful stimuli and reflexes are present; and if there is little reason to expect further absorption of the drug from the gastrointestinal tract adequate nursing care is all that is needed. The patient who cannot be aroused usually has depressed and obstructed respiration, accumulation of secretion, cyanosis, frequently pulmonary rales, fall in blood pressure and lowered body temperature. The immediate care is directed toward correcting these conditions.

The airway must be cleared, secretions removed, oxygen administered, artificial respiration instituted if necessary. Glucose, blood or plasma are given, cautiously because of the

pulmonary edema. Vaso constrictors may be given intermittently or in a continuous infusion if the blood pressure is low. The patient is kept warm and turned frequently. Massive doses of Penicillin are used.

There is still controversy on two points in the management:

- 1. Is aspiration of the stomach justified when the drug has been ingested hours before and absent reflexes encourage the pulmonary aspiration of stomach contents
- 2. Are central nervous stimulants indicated? There is little evidence that the immediate mortality is less with their use. It is possible that some patients have died because of their use. Respiratory complications may be less due to early return to consciousness and cooperation from the patient.

Since the introduction of Nallyl-nor-morphine it has become important to differentiate drug intoxication of the narcotic drugs from that of the hypnotics. Nalline is an antidote for the respiratory depression of the narcotic drugs but is contraindicated for the hypnotics.

A.M.A. Judicial Council Member

Homer Pearson, member of the Judicial Council of the AMA and former member of the House of Delegates of the AMA, will address the House of Delegates of the Georgia Medical Association Sunday on the activities and duties of the Judicial Council. He received his M.D. degree from Emory University School of Medicine. Dr. Pearson is engaged in



Homer Pearson, M.D.

the practice of Obstetrics and Gynecology in Miami, Florida. He is past president of the Dade County Medical Association and Florida Medical Association, secretary of the Florida Board of Medical examiners, and diplomate of the American Board of Obstetrics and Gynecology.

Anesthesiologist to Talk



Col. Harvey C. Slocum, M.C.

Harvey C. Slocum, Chief of Anesthesiology and Operating Section, Walter Reed Army Hospital, Washington, received his M.D. degree from the University of Buffalo.

Colonel Slocum was formerly Clinical Professor of Anesthesiology, Baylor University Graduate School of Medicine. Colonel Slocum's paper, to be presented Tuesday May 4, entitled "Altered Respiratory Physiology in Patients with Chest Disease and the Effects on the Conduct of Anesthesia" is summarized below.

The patient with disease processes involving the pulmonary mechanisms may be subjected to surgical treatment. The operative procedure may be in relation to or incidental to the pulmonary disease.

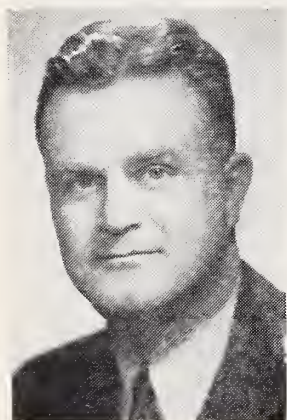
In each case the anesthesiologist is the physician assigned to be responsible for the care of the patient during the administration of anesthetic drugs and the conduct of the surgical procedure.

For the anesthesiologist to function as an integrated part of this medical-surgical team would indicate not only a thorough knowledge of anesthetic drugs and technics, but an adequate knowledge of the cardio-respiratory physio-pathology associated with the pulmonary function of each patient.

A patient may have altered respiratory physiology due to acute or chronic infections of the tracheo-bronchial tree or pulmonary bed, tumors of the bronchii or lung fields, space occupying lesions of the mediastinum or chest wall, trauma to the lung, rib cage or diaphragm, shift of the mediastinum, variables in intrapleural pressure and many other factors. In each case the conduct of anesthesia must be attuned to the physiological variables of decreased vital capacity and ventilatory deficiencies.

This paper considers many of the problems which are presented to the anesthesiologist in the care of patients with pulmonary disease.

Urology Speaker



Victor F. Marshall, M.D.

Victor F. Marshall, Director of Urology, James Buchanan Brady Foundation of the New York Hospital-Cornell Medical Center; Associate Professor of Clinical Surgery (Urology) at Cornell University Medical College; and Associate Surgeon at the Memorial Center for Cancer and Allied Diseases, New York City, received his M.D. degree from the University of Virginia Medical School in 1937. The subject of Dr. Marshall's paper to be given on Monday, May 3, before the Section on Urology, is "The Prevention of Renal Phosphatic Calculi", a summary of which follows:

A diet containing only 1300 milligrams of phosphorus, in combination with forty cubic centimeters of basic aluminum carbinat gel four times a day will, in approximately ninety per cent of patients, reduce the phosphate output to less than three hundred milligrams per day. This three hundred milligrams output appears to be the critical level below which it is extremely difficult for phosphatic stones to form. This program is called by us the "Shorr Regimen", after Dr. Ephraim Shorr of our Institution, who devised it. I shall present thirty-nine patients with an average pre-regimen study of fifty-two months, compared with their course on an average of forty-nine months while on the program. The drastic reduction in urinary calculi seems to demonstrate the effectiveness of this regime. It will be pointed out that the program is not easy to manage but that it is highly effective and, most particularly, it is still highly effective for the patient with the poor renal function and marked infection. Finally, several cases in which staghorn calculi have been removed by complete nephrotomy will be briefly discussed.

OB and GYN Speaker

Franklin L. Payne, who will address the Section on Obstetrics and Gynecology on "Modern Significance of Post Menopausal Bleeding", received his M.D. degree from the University of Pennsylvania Medical School.

He is Chairman, Department of Obstetrics and Gynecology, University of Pennsylvania Medical School. A summary of his paper follows:



Franklin L. Payne, M.D.

Due to lay education, hormone therapy, more alert professional care and additional clinical experience the significance of post-menopausal bleeding has changed during the past twenty years. A study of 600 patients as reported in 1936 revealed a malignant incidence of 61 per cent as opposed to an incidence of 32 per cent in the present study of 624 patients who were admitted to the Hospital of the University of Pennsylvania with post-menopausal bleeding between January 1, 1941 and January 1, 1951. Depending upon the final diagnosis the last series is divided into three groups: Benign, malignant and uncertain. The benign group is studied as to: the "clear span" between the onset of amenorrhea and the start of bleeding, the site from which the bleeding arose and the responsible pathologic process. The malignant group is analyzed as to: the site of the malignant lesion and the "clear span" in relation to the site of the lesion. The uncertain group, consisting of 10 per cent of the series, is studied in relation to the systemic and local pathologic findings, the type of endometrium and subsequent developments. Finally attention is called to an interesting clinical relationship between cervical polyps and post-menopausal bleeding.

CDC Representative



Morris Schaeffer, M.D.

Morris Schaeffer, Medical Director in Charge, Virus and Rickettsia Section, Communicable Disease Center, U. S. Public Health Service, Montgomery, Alabama, who received the Ph.D. degree and his M.D. degree from New York University, will address the General Clinical Session Monday on "Current Developments in Immunization Against Poliomyelitis". Dr. Schaeffer was assistant professor of Pediatrics, Western Reserve University School of Medicine and Medical Director, Department of Contagious Diseases, Cleveland City Hospital before coming to Montgomery. He is a founder member of the American Board of Preventive Medicine and Public Health.

GUEST SPEAKERS (Cont'd.)

Industrial Surgery Speaker



Nelson K. Ordway, M.D.

William G. Thuss, head of the Thuss Clinic, Industrial and Orthopedic Surgery, Birmingham, Ala., will address the Section on Industrial Surgery and Medicine Tuesday, May 4, on the subject "Disability Evaluation".

He received his M.D. degree at Vanderbilt University School of Medicine and was resident surgeon at St. Luke Hospital, New

York City. He has been practicing Industrial and Traumatic Surgery since 1928.

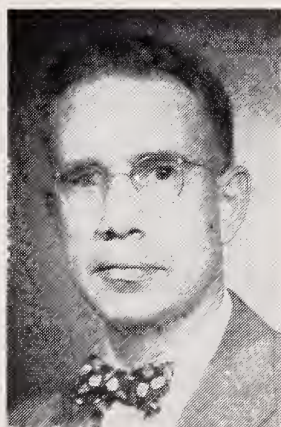
"Disability Evaluation" has been selected for presentation because it is a troublesome subject, and many doctors are called upon to give an accurate appraisal of injuries in order that a monetary value might be placed on claims.

Unfortunately, this subject is not taught in the various medical schools. It has been generally recognized that there is no schedule or formula that can adequately define and classify all the variations of physical disability. I have attempted to make a survey and to set up a workable plan or formula whereby the examining physician can arrive at a reasonably accurate conclusion.

Pediatrics Speaker

Nelson Kneeland Ordway, Head of Pediatrics, Louisiana State University School of Medicine, who will speak on Monday to the General Clinical Session, will have as his topic "The Diagnosis and Management of Patients with Congenital Heart Disease".

Dr. Ordway received his M.D. degree from Yale University School of Medicine and was Instructor in Pediatrics there before going to Louisiana. He rose from Assistant Professor of Pediatrics at Louisiana State University School of Medicine in 1947 to head of the department in 1952. He is a member of the American Board of Pediatrics, Society for Pediatric Research, American Academy of Pediatrics, American Pediatric Society and American Medical Association. He is active in several civic capacities in connection with retarded children and mental hygiene.



William G. Thuss, M.D.

TECHNICAL EXHIBITS

(Entrance Corridor, Auditorium)

BOOTH

COMPANY

3. Hoffman-LaRoche, Inc., Roche Park, Nutley 10, N. J.
6. The P. Lorillard Co., 119 W. 40th St., New York, N. Y.
12. Kremers-Urban Company, 141 West Vine Street, Milwaukee 12, Wis.
13. Wachtel's Physician Supply Company, 406 Bull Street, Savannah, Ga.
14. J. B. Roerig Company, 536 Lakeshore Drive, Chicago, Ill.
15. McNeil Laboratories, Inc., 2900 N. 17th Street, Philadelphia 32, Penn.
16. Harrower Labs, 930 Newark Ave., Jersey City, N. J.
18. Estes Surgical Supply Company, 56 Auburn Avenue, NE, Atlanta, Ga.
19. A. H. Robins Company, Inc., 1407 Cummings Drive, Richmond, Va.
20. The Doho Chemical Corp., 100 Varick Street, New York 13, N. Y.
22. C. B. Fleet Company, Inc., Drawer 1100, Lynchburg, Va.
24. Abbott Laboratories, North Chicago, Ill.
25. Ortho Pharmaceutical Corp., Raritan, N. J.
26. Brown & Williamson Tobacco Corp., 1600 West Hill Street, Louisville, Ky.
27. Bristol-Myers Products Division, 630 Fifth Avenue, New York 20, N. Y.
28. Brayten Pharmaceutical Company, Chattanooga 8, Tenn.
29. General Electric Company, X-Ray Dept., 1383 Spring Street, Atlanta, Ga.
30. Coca-Cola Company, P. O. Drawer 1734, Atlanta, Ga.
31. Spinks Scale Co., 584 Manford Road, Atlanta.
32. Spinks Scale Co., 584 Manford Road, Atlanta.
33. Warner-Chilcott Laboratories, 113 W. 18th Street, New York 11, N. Y.
35. Sherman Labs, 14600 E. Jefferson Ave., Detroit, Mich.
36. S&H X-Ray Labs., 501 Peachtree St., Atlanta.
37. Winthrop-Stearns, Inc., 1450 Broadway, New York 18, N. Y.
38. Parke, Davis & Company, Detroit 32, Mich.
39. American Surgical Supply Company, 489 Peachtree Street, NE, Atlanta, Ga.
40. Surgical Selling Company, 139 Forrest Avenue, NE, Atlanta, Ga.
41. M. & R. Laboratories, Inc., 585 Cleveland Avenue, Columbus 16, Ohio
42. U. S. Vitamin Corp., 250 East 43rd Street, New York 17, N. Y.
43. The Stuart Company, 352 Wacker Drive, Chicago 1, Ill.
44. Lederle Laboratories, Division of American Cyanamid Company, Pearl River, N. Y.
45. Ames Company, Inc., 819 McNaughton Street, Elkhart, Ind.
46. Hart Drug Corp., 1062 Maryland Avenue, NE, Atlanta, Ga.
47. Sandoz Chemical Works, Inc., 68 Charlton Street, New York 14, N. Y.
48. Julius Schmid, Inc., 423 West 55th Street, New York 19, N. Y.
49. Ayerst, McKenna & Harrison, Ltd., 22 East 40th Street, New York 16, N. Y.
50. S. E. Massengill Company, 527 Fifth Street, Bristol, Tenn.
51. A. S. Aloe Company, 492 Peachtree Street, NE, Atlanta, Ga.
52. A. S. Aloe Company, 492 Peachtree Street, NE, Atlanta, Ga.
53. Sharp & Dohme, Inc., 640 North Broad Street, Philadelphia 1, Penn.
54. Irwin-Neisler & Company, Decatur, Ill.
55. E. R. Squibb & Sons, 745 Fifth Avenue, New York 22, N. Y.
56. Ciba Pharmaceutical Products, Inc., LaFayette Park, Summit, N. J.
57. Wm. P. Poythress & Company, Inc., Richmond, Va.
58. Pet Milk Company, 1401 Arcade Building, St. Louis, Mo.
59. Charles Pfizer & Company, Inc., 630 Flushing Avenue, Brooklyn 6, N. Y.
60. Eli Lilly & Company, P. O. Box 618, Indianapolis 6, Ind.
61. Van Pelt & Brown, Inc., 1322 East Main Street, Richmond, Va.

IN MEMORIAM

ALLEN, Myron B., Houshton, July 20, 1953
 BAXTER, J. H., Ashburn, October 13, 1953
 BINION, Richard, Milledgeville, October 21, 1953
 BOLAND, Frank K. Sr., Atlanta, November 11, 1953
 BROWNING, Zack, Augusta, May 2, 1953
 BRYANS, Charles Iverson, Augusta, July 18, 1953
 BUTLER, Clarence G., Gainesville, November 30, 1953
 CARTER, Curtis Braxton, Columbus, October 6, 1953
 CATRON, Isaac T., Atlanta, December 23, 1953
 COCHRAN, M. F., Newnan, June 17, 1953
 COLEMAN, Y. R., Jonesboro, December 3, 1953
 DANIEL, John W., Savannah, January 1, 1954
 DAVISON, Thomas C., Atlanta, September 17, 1953
 DORMINEY, James Norwood, Cordele, August 2, 1953
 EAVES, B. F., Draketown, April 1, 1953
 FISCHER, Luther C., Atlanta, April 29, 1953
 FLEMING, Albert, Folkston, July 7, 1953
 FORT, Mannie A., Bainbridge, May 9, 1953
 FUTCH, Thomas Allen, Jr., Thomasville, March 20, 1953
 GOODWIN, Henry J., Jr., Douglas, January 27, 1954
 GOOLSBY, Robert Cullen, Sr., Forsyth, February 3, 1954
 HARDMAN, Charles Terrell, Tallulah Falls, October 4, 1953
 HENDRY, Wayland M., Jr., Washington formerly Atlanta, November 16, 1953
 HIGHSMITH, Emmett deWitt, Atlanta, August 11, 1953
 HOGUE, W. L., Villa Rica, January 19, 1954
 HUSON, William Joseph, Covington, June 27, 1953
 IRVIN, I. W., Albany, April 25, 1953
 KING, William Russell Sr., Tennille, December 9, 1953
 LOTT, John J., Broxton, August 8, 1953
 McCORD, Mather Marvin, Rome, December 14, 1953
 McFARLANE, John W., Macon, July 1, 1953
 MILES, William C., Griffin, July 12, 1953
 MOORE, Henry McIntosh, Thomasville, December 29, 1953
 NEVILLE, John C., Register, June 23, 1953
 PATRICK, J. Z., Pulaski, December 28, 1953
 PATTON, Lewis N., Athens, June 24, 1953
 PITTMAN, James Lee, Atlanta, January 21, 1954
 PRICE, William Thomas, Augusta, September 24, 1953
 SMITH, D. D., Swainsboro, March 15, 1953
 SMITH, James M., Cochran, July 31, 1953
 STAMPA, Samuel, Atlanta, November 4, 1953
 STATON, Torrence R., Atlanta, May 7, 1953
 STRICKLER, Cyrus W., Atlanta, July 23, 1953
 TIMMONS, Carl Conrad, Augusta, November 9, 1953
 WHELAN, Edward J., Savannah, July 10, 1953
 YEOMANS, Una Ritch, Jesup, January 10, 1954

Georgia Physicians Who Have Practiced Medicine Fifty Years

This list does not contain the names of all Georgia Physicians who have practiced medicine 50 years or more. This list records the class of 1954 *only*.

Battey, W. W.; Augusta
 Calhoun, F. Phinzy; Atlanta
 Davis, E. B.; Byromville
 Erwin, Harlan L.; Dalton
 Funkhouser, William L.; Atlanta
 Graham, Rufus E.; Savannah
 Hagood, George F.; Marietta

Lipscomb, William E.; Cumming
 Martin, Robert V.; Savannah
 May, Ellis R.; Lincolnton
 Riley, B. F. Jr.; Thomson
 Rollins, John C.; College Park
 Westbrook, R. J.; Ila

SCIENTIFIC EXHIBITS

(Entrance Corridor, Auditorium)

1. "Cancer of the Lung"—American Cancer Society, Atlanta.
2. "Bacterial Endocarditis"—Cardiology Section, Department of Internal Medicine, Emory University School of Medicine.
3. "The Use of Preserved Arterial Homografts and Repair of Aortic Aneurysms," Robert G. Ellison, Augusta.
4. "The Placenta—Variations in Depth of Implantation and Its Relation to Spontaneous Abortion"—Richard Torpin, Augusta.
5. "Electroencephalography in Traumatic Head Injury"—John T. Manter, Augusta.
6. "Heart Models in Health and Disease"—Mr. Frank H. Colley, Georgia Heart Association, Atlanta.
7. "New Macon Hospital"—Mr. Wiley P. Jackson, Supt., Macon Hospital, Macon.
8. "Dramatic Results in the Specific Therapy of Tuberculosis"—Herbert M. Olnick, Macon.
10. "The Anesthesia Study Commission"—Lester Rumble, Jr., Atlanta.
11. "Cholangiography"—Milford B. Hatcher, Macon.
12. Laryngeal Carcinoma"—Murdock Euen, Atlanta.
13. "A Graphic Picture of Maternal and Infant Morbidity and Mortality in 1952, by County of Residence"—The Maternal and Infant Welfare Committee of the Medical Association of Georgia.
14. "Diagnostic Duodenal Drainage"—Napier Burson, Jr., Atlanta.
15. "A New Model for Demonstrating Spatial Vectors of the Electrocardiogram"—Crawford W. Long Hospital, Atlanta.
16. "Rehabilitation of the Hemiplegic"—Harriett E. Gillette, Atlanta.
17. "Headache"—Exum Walker, Atlanta.
18. "Home Safety Telequiz"—Public Health Education, Mr. George Stenhouse, Atlanta.
19. "Food Sanitation"—Public Health Education, Mr. George Stenhouse, Atlanta.
20. "Blue Shield Booth"—Blue Cross—Blue Shield, Mr. J. M. Galloway, Columbus.
21. "Cholecystography"—J. L. Clements, Jr., Atlanta.

THE PROGRAM

The following papers are announced to be read before the scientific sessions. The order here is not necessarily the order that will be followed in the Official Program, and minor changes may be required by conditions beyond the control of the MAG Committee on Scientific Work. Be sure to check your Official Program for final details.

H. ANSLEY SEAMAN, Chairman

Sunday Afternoon, May 2

1:00 REGISTRATION OF DELEGATES BY CREDENTIALS COMMITTEE CHAIRMAN

(All Delegates must present credentials from their county medical society for registration)

East Corridor, Main Floor, Auditorium

2:00 HOUSE OF DELEGATES MEETING

Main Floor, Auditorium

PRESIDING:

William Harbin, President, Rome

ORDER OF BUSINESS:

1. Call to Order
2. Roll Call—Chairman of Credentials Committee
3. Appointment of Reference and Other Committees
4. Election of Speaker and Speaker Pro Tem
5. Reading and Adoption of Minutes (See *JMAG*, June 1953)
6. Introduction of Distinguished Guests
7. Reports of Officers:
President—William Harbin, Rome
President-Elect—Peter B. Wright, Augusta
1st Vice President—J. C. Metts, Savannah
2nd Vice President—Milford B. Hatcher, Macon
Secretary-Treasurer—David Henry Poer, Atlanta
Councilor 1st District — Lee Howard, Savannah
Councilor 2nd District—George R. Dillinger, Thomasville
Councilor 3rd District—W. G. Elliott, Cuthbert
Councilor 4th District—J. W. Chambers, LaGrange
Councilor 5th District—Mark S. Dougherty, Jr., Atlanta
Councilor 6th District—H. Dawson Allen, Jr., Milledgeville
Councilor 7th District—D. Lloyd Wood, Dalton
Councilor 8th District—Neal F. Yeomans, Waycross
Councilor 9th District—W. Bruce Schaefer, Toccoa
Councilor 10th District—H. L. Cheves, Union Point
Vice-Councilor 1st District—Charles T. Brown, Guyton
Vice-Councilor 2nd District—Carl S. Pittman, Tifton
Vice-Councilor 3rd District—Guy J. Dillard, Columbus
Vice-Councilor 4th District—Clarence B. Palmer, Covington
Vice-Councilor 5th District—J. G. McDaniel, Atlanta
Vice-Councilor 6th District — H. G. Weaver, Macon
Vice-Councilor 7th District—Ralph W. Fowler, Marietta
Vice-Councilor 8th District—James N. Hicks, Brunswick
Vice-Councilor 9th District—Charles R. Andrews, Jr., Canton
Vice-Councilor 10th District—J. Victor Roule, Augusta
8. Report of Council—H. L. Cheves, Chairman, Union Point
9. Reports of Committees
Standing Committees:
Committee on Scientific Work, H. Ansley Seaman, Chairman, Waycross
Committee on Legislation, Carl C. Aven, Chairman, Atlanta
Committee on Medical Education, R. Hugh Wood, Chairman, Atlanta
Committee on Medical Defense, Marion C. Pruitt, Chairman, Atlanta
Committee on Professional Conduct, Ralph Chaney, Chairman, Augusta
Committee on History and Vital Statistics, J. Calvin Weaver, Chairman, Atlanta
Committee on Public Health, T. A. Sappington, Chairman, Thomaston
Committee on Maternal and Infant Welfare, Peter Hydrick, Chairman, College Park
Committee on Rural Health, W. W. Turner, Chairman, Nashville
Committee on Industrial Health, Duncan Shepard, Chairman, Atlanta
Committee on Public Relations, Chris J. McLoughlin, Chairman, Atlanta
Committee on Cancer, J. E. Scarborough, Chairman, Atlanta
Insurance Board, John L. Elliott, Chairman, Savannah
Committee on Hospitals, R. F. Spanjer, Chairman, Cedartown
Committee on Constitution and By-Laws, Allen H. Bunce, Chairman, Atlanta
Special Committees:
Advisory Committee to the Woman's Auxiliary, Ralph Chaney, Chairman, Augusta

Awards Committee, Mark S. Dougherty, Jr., Chairman, Atlanta
 American Medical Education Foundation Committee, E. Van Buren, Chairman, Atlanta
 Committee on Blood Banks, J. C. Thorougman, Chairman, Atlanta
 Abner Wellborn Calhoun Lectureship Committee, Glenville Giddings, Chairman, Atlanta
 Medical Civil Preparedness Committee, Edgar M. Dunstan, Chairman, Atlanta
 Veterans' Affairs Committee, Hartwell Joiner, Chairman, Gainesville
 Chronic Illness Committee, L. Minor Blackford, Chairman, Atlanta
 Liaison Advisory Board to the Georgia Society for Crippled Children Committee, H. Walker Jernigan, Chairman, Atlanta
 Medical Advisory to Selective Service System Committee, A. O. Linch, Chairman, Atlanta
 Crawford W. Long Memorial Committee, Lester Rumble, Jr., Chairman, Atlanta
 Mental Health Committee, J. R. Shannon Mays, Chairman, Macon
 Advisory Board to the Clarke-Oconee County Study, Mark S. Dougherty, Jr., Chairman, Atlanta

10. Report of Honorary Advisory Board, C. F. Holton, Chairman, Savannah
11. Report of State Board of Health, R. Lee Rogers, Chairman, Gainesville
12. Report of State Board of Medical Examiners, Alex B. Russell, Chairman, Winder
13. Report of State Medical Education Board, C. L. Howard, Chairman, Pelham
14. Report of AMA Delegates, Charles H. Richardson, Sr., Macon, and Eustace A. Allen, Atlanta
15. Report of the Journal, David Henry Poer, Edgar Woody, Jr. and Mr. John F. Kiser, Atlanta
16. Report of Executive Secretary, Mr. Milton D. Krueger, Atlanta
17. Unfinished Business
18. New Business (Resolutions will be introduced at this time)
19. Special Reports

ACTIVITIES OF THE AMA JUDICIAL COUNCIL
 H. L. Pearson, AMA Judicial Council Member, Miami, Florida

LEGISLATIVE ACTIVITIES OF THE AMA
 Walter Martin, AMA President-Elect, Norfolk, Va.

WOMAN'S AUXILIARY

Mrs. Leo Smith, Auxiliary President, Waycross

BETTER HEALTH COUNCIL

Mrs. Bruce Schaefer, Acting Chairman, Toccoa

THE GEORGIA NUTRITION COUNCIL

Guy V. Rice, Chairman, Atlanta

20. RECESS

2:00 GEORGIA RADIOLOGICAL SOCIETY

Blue Flame Room, Macon Natural Gas Bldg., 332 2nd Street

PRESIDING:

Stephen W. Brown, Augusta

1. FILM READING SESSION
2. BUSINESS SESSION
3. ELECTION OF 1955 PROGRAM CHAIRMAN

3:00 GEORGIA SOCIETY OF ANESTHESIOLOGISTS

Mirror Room, Dempsey Hotel

PRESIDING:

C. M. Westerfield, Savannah

1. DISCUSSION OF ANESTHESIA STUDY COMMISSION
2. BUSINESS SESSION
3. ELECTION OF 1955 PROGRAM CHAIRMAN

3:00 GENERAL REGISTRATION

(Bring Membership Card)

East Corridor, Main Floor, Auditorium

Tickets available for: 1. Sunday Buffet Supper, *Dempsey Hotel*; 2. Tuesday President's Dinner, *Idle Hour Country Club* and, 3. Wednesday Special Guests Luncheon, *Dempsey Hotel*. Wives are most cordially invited to attend these events, dress optional.

Tickets should be purchased at time of registration. Eating facilities at all places are limited. The Local Arrangements Committee cannot be responsible unless each member cooperates in this manner.

Only enough tickets will be available to conform with seating limits. This is your official notice—please be governed accordingly.

4:30 JOINT MEMORIAL SERVICE WITH WOMAN'S AUXILIARY

Main Floor, Auditorium

PRESIDING:

William Harbin, President, Rome

INVOCATION:

Dr. Albert Grady Harris, Minister, First Presbyterian Church, Macon

SOLO: ONE SWEETLY SOLEMN THOUGHT

Miss Alice Ann Hamilton, accompanied by Mr. Crockett Odom, Macon

MEMORIAL SERVICE

Dr. Albert Grady Harris

IN MEMORIAM:

MEDICAL ASSOCIATION OF GEORGIA

J. Calvin Weaver, Atlanta

WOMAN'S AUXILIARY TO THE MEDICAL ASSOCIATION OF GEORGIA

Mrs. Harold Atkinson, Macon

SOLO: THE LORD'S PRAYER

William W. Orr, accompanied by Mr. Crockett Odom, Macon

Monday Morning, May 3

8:15 SECTION ON RADIOLOGY (All Physicians Invited)

Blue Flame Room, Macon Natural Gas Bldg., 332 2nd Street

PRESIDING:

Stephen Brown, Augusta

Discussion to be called for if time permits

8:15 ASSEMBLY

8:25 ANNOUNCEMENTS

8:30 HYPOPHOSPHATASIA

E. B. D. Neuhauser, Boston, Mass.

9:00 RETROPERITONEAL LIPOSARCOMAS

Ted F. Leigh and James V. Rogers, Atlanta

9:20 ADVANCES IN CHOLECYSTOGRAPHY

Richard A. Elmer and J. L. Clements, Jr., Atlanta

9:40 TUMORS OF THE COLON

Robert Pendergrass, Americus

10:00 PREVALENCE OF SCURVY IN SOUTH GEORGIA

Frank Eldridge, Valdosta

VIEW EXHIBITS

8:15 SECTION ON UROLOGY (All Physicians Invited)

Main Floor, Auditorium

PRESIDING:

J. Robert Rinker, Augusta

Discussion to be called for if time permits

8:15 ASSEMBLY

8:25 ANNOUNCEMENTS

8:30 TUMORS OF THE TESTICLE

David C. Williams, Jr., Augusta

8:50 NONGONOCOCCAL URETHRITIS: DIAGNOSIS AND THERAPY

Samuel S. Ambrose, Atlanta

9:10 SURGICAL TREATMENT OF URINARY STRESS INCONTINENCE IN WOMEN

John Ridley, Jr., Atlanta

9:30 T. B. EPIDIDYMYTIS

J. Robert Rinker, Augusta

DISCUSSORS:

Robert McAllister, Macon, and Charles Eberhart, Atlanta

10:00 THE PREVENTION OF RENAL PHOSPHATIC CALCULI

Victor Marshall, New York, N. Y.

10:25 ELECTION OF 1955 PROGRAM CHAIRMAN

10:30 VIEW EXHIBITS

8:15 SECTION ON ANESTHESIOLOGY (All Physicians Invited)

Kilowatt Room, Georgia Power Co. Bldg., 667 Cherry Street

PRESIDING:

C. W. Westerfield, Savannah

Discussion to be called for if time permits

8:15 ASSEMBLY

8:25 ANNOUNCEMENTS

8:30 SYMPOSIUM: MANAGEMENT OF THE COMATOSE PATIENT

MODERATOR:

Col. Harvey Slocum, Washington, D. C.

COMA OF PRIMARY C.N.S. ORIGIN

L. O. J. Manganiello and Pomeroy Nichols, Augusta

COMA IN THE DIABETIC AND UREMIC PATIENT

Curtis Carter, Augusta

COMA DUE TO DRUG OVERDOSAGE

Alice McNeal, Birmingham, Ala.

QUESTIONS AND ANSWERS

10:30 VIEW EXHIBITS

8:15 JOINT SECTION ON PEDIATRICS AND ORTHOPEDICS (All Physicians Invited)

Civic Room, Downstairs Auditorium

PRESIDING:

Harold W. Muecke, Waycross, and Fred G. Hodgson, Atlanta

Discussion to be called for if time permits

8:15 ASSEMBLY

8:25 ANNOUNCEMENTS

8:30 CAT SCRATCH FEVER

Harry B. O'Rear, Augusta

8:50 TREATMENT OF ERYTHROBLASTOSIS FETALIS WITH REPLACEMENT TRANSFUSION

H. Luten Teate, Jr., Atlanta

9:10 SYMPOSIUM: ORTHOPEDIC CONDITIONS IN CHILDHOOD

MODERATOR:

T. P. Waring, Savannah

9:10 CONGENITAL DYSPLASIA OF HIPS

Jack C. Hughston, Columbus

9:25 TORSION OF THE LEGS IN SMALL CHILDREN

J. Hiram Kite, Atlanta

9:40 EHLER-DANLOS SYNDROME

Peter B. Wright, Augusta

9:55 ILIO-TIBIAL BAND SYNDROME

C. E. Irwin, Warm Springs

10:15 DISCUSSION LED BY:

Nelson Ordway, New Orleans, La.

10:25 ELECTION OF 1955 PROGRAM CHAIRMEN

10:30 VIEW EXHIBITS

10:45 GENERAL SESSION

Main Floor, Auditorium

PRESIDING:

William Harbin, President, Rome

10:45 INVOCATION

Rev. Luke Smith, Highland Hills Baptist Church, Macon

10:50 ADDRESSES OF WELCOME:

1. Hon. B. F. Merritt, Jr., Mayor of Macon

2. Milford B. Hatcher, President, Bibb County Medical Society, Macon

- 11:00 LESIONS OF THE LOWER ESOPHAGUS AS A CAUSE OF VOMITING IN INFANTS
E. B. D. Neuhauser, Boston, Mass.
- 11:30 YOUR AMA IS WHAT YOU MAKE IT
Walter Martin, AMA President-Elect, Norfolk, Va.
- 12:00 PRESIDING:
J. C. Metts, 1st Vice President, Savannah
- 12:00 PRESIDENT'S ADDRESS
William Harbin, President, Rome
- 12:30 NOMINATION OF OFFICERS:
Announcement of Tellers Committee and Voting Rules
1. President-Elect
 2. 1st Vice President
 3. 2nd Vice President
 4. Secretary-Treasurer
 5. Two AMA Delegates (Terms beginning January 1, 1955)
 6. Two AMA Alternates (Terms beginning January 1, 1955)
 7. Councilor—9th District
 8. Councilor—10th District

9. Vice Councilor—9th District
 10. Vice Councilor—10th District
- ANNOUNCEMENTS

- 1:00 SPECIALTY SOCIETY LUNCHEONS**
(Luncheons Must Start Promptly at 1:00 p.m. and Adjourn Promptly at 2:00 p.m.)
- 1:00 1. GEORGIA PEDIATRICS SOCIETY
William C. Boswell, Chairman, Macon
Elks Club, 841 Mulberry Street
- 1:00 2. GEORGIA UROLOGICAL SOCIETY
Willard R. Golsan, Chairman, Macon
Pine Room, Dempsey Hotel
- 1:00 3. GEORGIA RADIOLOGICAL SOCIETY
Herbert M. Olnick, Chairman, Macon
Mirror Room, Dempsey Hotel

2:00 BALLOT BOX OPEN—Location and Rules
Posted on Official Bulletin Board —
VOTE EARLY

Monday Afternoon, May 3

2:15 GENERAL CLINICAL SESSION

Main Floor, Auditorium

PRESIDING:

Milford B. Hatcher, Macon

Discussion to be called for if time permits

2:15 ASSEMBLY

2:25 ANNOUNCEMENTS

2:30 *THE DIAGNOSIS AND MANAGEMENT OF PATIENTS WITH CONGENITAL HEART DISEASE
Nelson Ordway, New Orleans, La.

*Presented in honor of Benjamin Bashinsky, M.D., by Baker Laboratories

3:00 MANAGEMENT OF BLADDER TUMORS
Victor Marshall, New York, N. Y.

3:30 SYMPOSIUM ON POLIOMYELITIS

MODERATOR:

Joseph Yampolsky, Atlanta

3:30 PATHOGENESIS OF POLIOMYELITIS
William Friedewald, Atlanta

3:50 CURRENT DEVELOPMENTS IN IMMUNIZATION AGAINST POLIOMYELITIS
Morris Schaeffer, Montgomery, Ala.

4:20 ACTIVITIES FOLLOWING ACUTE ANTERIOR POLIOMYELITIS
Robert L. Bennett, Warm Springs

4:40 DISCUSSION

4:50 PANEL: PYURIA IN CHILDHOOD

MODERATOR:

Charles L. Prince, Savannah

SPEAKERS:

1. Victor Marshall, New York, N. Y.

2. Nelson Ordway, New Orleans, La.

3. E. B. D. Neuhauser, Boston, Mass.

4. J. J. Clark, Atlanta

Monday Evening, May 3

7:30 ALUMNI DINNERS

7:30 EMORY UNIVERSITY SCHOOL OF MEDICINE
Edmund A. Brannen, Chairman, Macon
Pinebrook Inn, Route 41, Forsyth Road

7:30 MEDICAL COLLEGE OF GEORGIA

William L. Barton, Chairman, Macon
Walter Little Room, Dempsey Hotel

7:30 TULANE UNIVERSITY OF LOUISIANA SCHOOL OF MEDICINE

Henry H. Tift, Chairman, Macon
Jeff Davis Room, Lanier Hotel, 555 Mulberry Street

Tuesday Morning, May 4

BALLOT BOX OPEN 9:00 A.M. - 5:00 P. M.
VOTE EARLY

8:15 JOINT SECTIONS ON GENERAL PRACTICE AND PEDIATRICS (All Physicians Invited)

Main Floor, Auditorium

PRESIDING:

Harry L. Cheves, Union Point

8:15 ASSEMBLY

8:25 ANNOUNCEMENTS

8:30 SYMPOSIUM: HEADACHE

MODERATOR:

M. F. Arnold, Hawkinsville

SPEAKERS:

1. W. O. White, Augusta

2. James T. King, Atlanta

3. Bruce Logue, Atlanta

4. Joseph Wilson, Atlanta

5. Edgar Hull, New Orleans, La.

QUESTIONS AND ANSWERS

10:20 ELECTION OF 1955 PROGRAM CHAIRMEN

10:30 VIEW EXHIBITS

8:30 UNUSUAL CASES OF AORTIC INSUFFICIENCY
Hugh Sealy, J. Willis Hurst and Bruce
Logue, Atlanta

8:50 PRESENT STATUS OF SURGERY OF ACQUIRED
HEART DISEASE
Osler Abbott and William Van Fleit,
Atlanta

9:10 ALTERED RESPIRATORY PHYSIOLOGY IN PA-
TIENTS WITH CHEST DISEASES AND THE
EFFECTS UPON THE CONDUCT OF ANES-
THESIA

Col. Harvey Slocum, Washington, D. C.

9:30 ROENTGENOLOGY IN HEART DISEASE
Simone Brocato, Columbus

9:50 OUTLOOK IN PATIENTS WITH MYOCARDIAL
INFARCTION
Edgar Hull, New Orleans, La.

10:25 ELECTION OF 1955 PROGRAM CHAIRMAN

10:30 VIEW EXHIBITS

VOTE NOW

8:15 SECTION ON INDUSTRIAL SURGERY AND MEDICINE (All Physicians Invited)

*National Guard Room, Downstairs Audi-
torium*

PRESIDING:

W. W. Battey, Augusta

Discussion to be called for if time permits

8:15 ASSEMBLY

8:25 ANNOUNCEMENTS

8:30 MEDICO-LEGAL ASPECTS OF HEAD INJURIES
Donald Bickers, Atlanta

9:00 HAND INJURIES AND TENDON REPAIR
Paul Reith, Atlanta

9:20 KNEE INJURIES
Joe Kurtz, Atlanta

9:40 CLAIM ANGLES
Mr. Landrum Finch, Atlanta

10:10 DISABILITY EVALUATION
William G. Thuss, Birmingham, Ala.

10:55 ELECTION OF 1955 PROGRAM CHAIRMAN

11:00 VIEW EXHIBITS

8:15 SECTION ON INTERNAL MEDICINE (All Physicians Invited)

Civic Room, Downstairs Auditorium

PRESIDING:

Thomas McGoldrick, Savannah

Discussion to be called for if time permits

8:15 ASSEMBLY

8:25 ANNOUNCEMENTS

8:15 SECTION ON OBSTETRICS AND GYNE- COLOGY (All Physicians Invited)

*Kilowatt Room, Georgia Power Co. Bldg.,
667 Cherry St.*

PRESIDING:

Hugh Bickerstaff, Columbus

Discussion to be called for if time permits

8:15 ASSEMBLY

8:25 ANNOUNCEMENTS

8:30 TRICHONOMAS VAGINALIS VAGINITIS
W. S. Clifford, Columbus

9:00 BLEEDING IN THE LAST TRIMESTER OF
PREGNANCY

William C. Shirley, Macon

9:30 MODERN SIGNIFICANCE OF POST MENOPAU-
SAL BLEEDING

Franklin L. Payne, Philadelphia, Pa.

10:30 VIEW EXHIBITS

VOTE

8:15 SECTION ON PATHOLOGY (All Physicians Invited)

*Blue Flame Room, Macon Natural Gas
Bldg., 332 2nd Street*

PRESIDING:

Lee Howard, Jr., Savannah

Discussion to be called for if time permits

8:15 ASSEMBLY

8:25 ANNOUNCEMENTS

8:30 SOME ASPECTS OF CARCINOMA IN SITU
Cyrus C. Erickson, Memphis, Tenn.

- 9:15 TRANSFUSION REACTIONS IN ATLANTA
Warren B. Matthews, Atlanta
- 9:35 REPORT ON 20 RENAL NEEDLE BIOPSIES
Walter H. Sheldon, Atlanta
- 10:00 BUSINESS SESSION AND ELECTION OF 1955
PROGRAM CHAIRMAN
- 10:30 VIEW EXHIBITS

**10:50 JOINT SESSION ON INTERNAL MEDICINE,
THORACIC DISEASES AND GENERAL
PRACTICE**

Main Floor, Auditorium

PRESIDING:

Fred Simonton, Chickamauga

10:50 ASSEMBLY

10:55 ANNOUNCEMENTS

11:00 PANEL: TREATMENT OF HYPERTENSION

SPEAKER:

Louis L. Battey, Augusta

DISCUSSORS:

1. Ellison R. Cook, III, Savannah

2. B. W. Forester, Macon

3. Edgar Hull, New Orleans, La.

4. Purcell Roberts, Atlanta

QUESTIONS AND ANSWERS

**10:50 JOINT SESSION ON PATHOLOGY AND
OBSTETRICS AND GYNECOLOGY**

*Kilowatt Room, Georgia Power Co. Bldg.,
667 Cherry St.*

PRESIDING:

Darrell Ayer, Atlanta

10:50 ASSEMBLY

10:55 ANNOUNCEMENTS

11:00 PANEL: CARCINOMA OF THE FEMALE GENITAL TRACT

MODERATOR:

Hugh Bickerstaff, Columbus

DISCUSSORS:

1. Franklin L. Payne, Philadelphia, Pa.

2. Cyrus C. Erickson, Memphis, Tenn.

3. Edgar Pund, Augusta

4. Sam A. Wilkins, Jr., Atlanta

QUESTIONS AND ANSWERS

1:00 SPECIALTY SOCIETY LUNCHEONS

(Luncheons Must Start Promptly at 1:00 p.m. and Adjourn Promptly at 2:00 p.m.)

1:00 1. GEORGIA SOCIETY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY

William L. Barton, Chairman, Macon
Pine Room, Dempsey Hotel

1:00 5. GEORGIA STATE OBSTETRICAL AND GYNE-
TICE

Frank M. Houser, Chairman, Macon
Mirror Room, Dempsey Hotel

1:00 3. GEORGIA CHAPTER, AMERICAN COLLEGE
OF SURGEONS

Charles N. Wasden, Chairman, Macon
*Jeff Davis Room, Lanier Hotel, 555 Mul-
berry St.*

1:00 4. GEORGIA CHAPTER OF CHEST SURGEONS
AND GEORGIA TRUDEAU SOCIETY

Sam E. Patton, Chairman, Macon
A and B Rooms, Dempsey Hotel

1:00 5. GEORGIA STATE OBSTETRICAL AND GYNE-
COLOGICAL SOCIETY

Jule C. Neal, Chairman, Macon
Elks Club, 841 Mulberry Street

1:00 6. GEORGIA ASSOCIATION OF PATHOLOGISTS

Max Mass, Chairman, Macon
S & S Cafeteria, 337 Third Street

VOTE

Tuesday Afternoon, May 4

**2:00 HOUSE OF DELEGATES SECOND MEETING
(Recessed)**

Civic Room, Downstairs Auditorium

PRESIDING:

Speaker of the House

ORDER OF BUSINESS:

1. Call to Order

2. Roll Call—Chairman of Credentials
Committee

3. Report of Reference Committee No. 1

4. Report of Reference Committee No. 2

5. Report of Reference Committee No. 3

6. Report of Reference Committee No. 4

7. Nomination of Members for State
Boards as Required by Georgia Law

8. Election of Life Members

9. Unfinished Business

10. New Business (For Information Only
—No Action Can Be Taken)

11. Recess

2:30 LEGAL CLINIC—THE DOCTOR AND THE LAW
ROUND TABLE DISCUSSION:

What the Law Says About Sterilization,
Adoption, Bastardy, Artificial Insemination
and Other Problems

Mr. John A. Dunaway, Atlanta, and Mr.
Cabbage Snow, Macon

QUESTIONS FROM THE FLOOR

**4:00 GENERAL SESSION ON LEGAL AND FI-
NANCIAL PROBLEMS**

Main Floor, Auditorium

PRESIDING:

Willard Golsan, Macon

4:00 SYMPOSIUM: THE DOCTOR AND HIS INCOME
LIFE INSURANCE

Mr. Armand Thorpe, Atlanta

TRUST FUNDS, WILLS AND TAXES

Mr. Harvey Hill and Mr. Frank Miller,
Atlanta

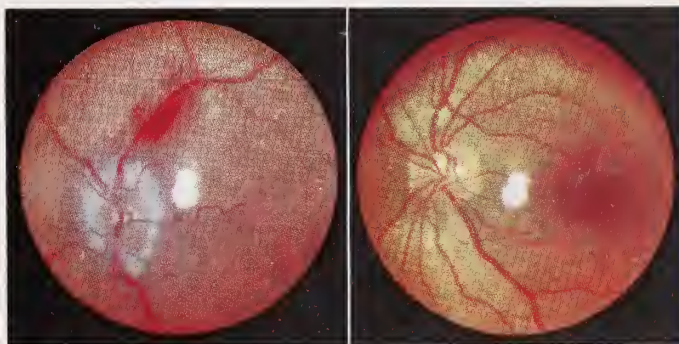
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APRESOLINE REDUCES DIASTOLIC PRESSURE

Diastolic pressure reduced to level considered normal in one-quarter and to 110 mm. Hg or less in one-third of 97 patients receiving oral Apresoline for periods ranging from 3 months to 1 year or longer;¹ hypertension in which neurogenic or psychogenic mechanisms predominated most improved; patients with severe as well as moderate hypertension benefited.

APRESOLINE LESSENS RETINAL ARTERIOLAR CONSTRICTION, RETINAL HEMORRHAGES*

Lessening of retinal arteriolar constriction; disappearance of retinal hemorrhages; remittance of hypertensive headaches, giddiness, paresthesias, transient pareses, and encephalopathies; some evidence of improved mental alacrity.



APRESOLINE INCREASES RENAL BLOOD FLOW

Renal improvement less marked than cerebral improvement, but renal blood flow and filtration rate increased and hematuria and proteinuria remitted in some cases; hypertensive heart disease little improved and, in some cases, worsened.

Side Effects: Side effects "minor, transient, or remediable" in most cases. Headache, gastrointestinal upset, periorbital and ankle edema, and a "grippe-like syndrome"—involving malaise and muscle and joint pain (see note)—observed.



Apresoline®

NOTE: Appearance of arthritis-like symptoms during Apresoline therapy is an indication for cessation of treatment. Experience has shown that the phenomenon remits spontaneously on withdrawal of the drug. These symptoms are not likely to occur in patients who receive a daily dose of 400 mg. or less.

FOR COMPLETE INFORMATION on Apresoline ask your CIBA representative or write Medical Service Division, CIBA Pharmaceutical Products, Inc., Summit, N. J. **SUPPLIED:** Apresoline hydrochloride (hydralazine hydrochloride CIBA) 10-mg. tablets (yellow, double-scored), 25-mg. tablets (blue, coated), and 50-mg. tablets (pink, coated) in bottles of 100, 500, and 1000; 100-mg. tablets (orange, coated) in bottles of 100 and 1000.

1. TAYLOR, R. D., DUSTAN, H. P., CORCORAN, A. C., AND PAGE, I. H.: ARCH. INT. MED. 90:734 (DEC.) 1952.

*THE NORMAL FUNDUS (RIGHT) AS COMPARED WITH THE FUNDUS IN HYPERTENSION SHOWING EDEMA, EXUDATES, AND HEMORRHAGES (LEFT); ILLUSTRATIONS FROM "THE FUNDUS OF THE EYE"; BEDELL, A. J.: CIBA CLINICAL SYMPOSIA 4:135 (JULY) 1952. THESE ILLUSTRATIONS ARE FOR DEMONSTRATION PURPOSES ONLY AND DO NOT REPRESENT APRESOLINE-TREATED PATIENTS.

C I B A



ALLEVIATES HAY FEVER, OTHER RESPIRATORY ALLERGIES

The above photos show a case of allergic rhinitis before and after Pyribenzamine therapy. Many such cases have been reported in the literature. A few examples: Loveless and Dworin¹ found Pyribenzamine beneficial in 82% of 107 patients; Feinberg² noted relief in 82% of 254 cases; Gay and associates³ in 76% of 51 cases; Arbesman and colleagues⁴ in 84% of 106 cases. In a later study Arbesman⁵ rated Pyribenzamine one of "the most effective of all the drugs studied in allergic rhinitis. . . ." *Side effects:* It has been stated that "undesirable symptoms from the use of 50 to 100 mg. doses of Pyribenzamine were rarely of sufficient severity to interfere with its use."⁶ Drowsiness, nausea, epigastric distress, vertigo and other side effects—rarely severe—may occur in some patients.

CONTROLS PENICILLIN REACTIONS

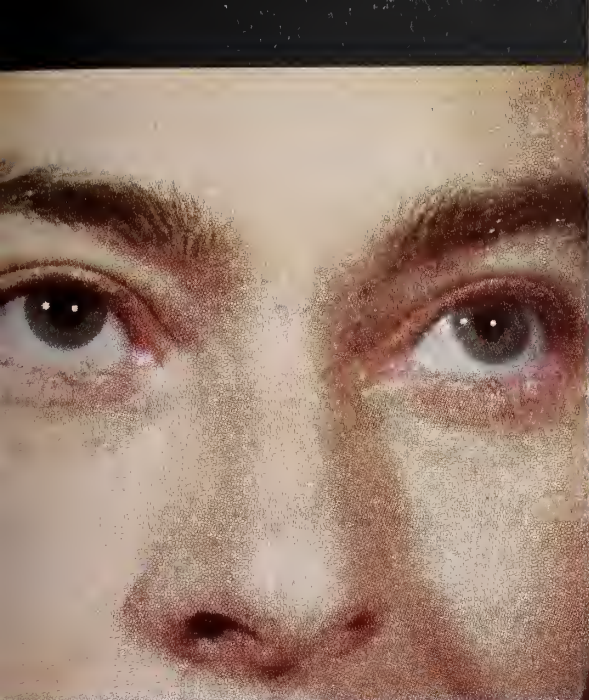
Pyribenzamine has been used successfully to control penicillin reactions—especially urticaria and itching. For example, Kesten⁷ found that oral Pyribenzamine relieved or suppressed post-penicillin urticaria in 16 of 18 cases; she termed it "a most useful agent in allergic symptoms which follow the administration of antitoxin or penicillin."

RELIEVES ALLERGIC DERMATOSES

Foster⁸ reported good results with oral Pyribenzamine in patients with various allergic dermatoses. In another study⁹ of 241 such patients, Pyribenzamine was found effective.



C I B A



*Pyribenzamine 25-mg.
tablets now available—
for children and for adults
who can be maintained
on low dosage or
who experience side effects
from the usual dosage
of antihistamines*

PUBLISHED CLINICAL STUDIES
SHOW THOUSANDS OF
ALLERGIC PATIENTS
RELIEVED BY

Supplied: Pyribenzamine hydrochloride 25-mg. and 50-mg. tablets; Pyribenzamine Elixir, 30 mg. Pyribenzamine citrate (equivalent to 20 mg. tripeleppamine hydrochloride) per 4-ml. teaspoonful; Pyribenzamine hydrochloride solution (for parenteral use), 25 mg. per ml., in 1-ml. ampuls.

Pyribenzamine[®]

PYRIBENZAMINE HYDROCHLORIDE (TRIPLEPPAMINE HYDROCHLORIDE CIBA)
PYRIBENZAMINE CITRATE (TRIPLEPPAMINE CITRATE CIBA)

REFERENCES

1. Loveless, M. H., and Dworin, M.: J. Am. M. Women's A. 4:105 (March) 1949.
2. Feinberg, S. M.: J.A.M.A. 132:702 (Nov. 23) 1946.
3. Gay, L. N., Landau, S. W., Carliner, P. E., Davidson, N. S., Furstenberg, F. F., Herman, N. B., Nelson, W. H., Parsons, J. W., and Winkenwerder, W. W.: Bull. Johns Hopkins Hosp. 83:356 (Oct.) 1948.
4. Arbesman, C. E., Koepf, G. F., and Lenzner, A. R.: J. Allergy 17:275 (Sept.) 1946.
5. Arbesman, C. E.: J. Allergy 19:178 (May) 1948.
6. Feinberg, S. M., and Friedlaender, S.: Am. J. M. Sc. 213:58 (Jan.) 1947.
7. Kesten, B. M.: Ann. Allergy 6:408 (July-Aug.) 1948.
8. Foster, P. D.: California Med. 73:413 (Nov.) 1950.
9. Morrow, G.: California Med. 69:22 (July) 1948.

For complete information on Pyribenzamine ask your CIBA representative or write Medical Service Division, CIBA Pharmaceutical Products, Inc., Summit, N. J.



INCREASES PERIPHERAL BLOOD FLOW:

Priscoline reported to be a valuable aid to conventional therapy in peripheral ischemia and its sequelae—pain, loss of function, ulceration, gangrene, other trophic manifestations; Priscoline most effective when vasospasm is prominent but may prove limb-saving even when vasospasm is minimal because it decreases vascular tone, promotes establishment of collateral circulation.

MULTIPLE ACTION:

Priscoline exerts direct vasodilating effect on vessel wall, blocks sympathetic nerves (probably at their terminations in vascular muscle), blocks vasoconstrictive action of circulating epinephrine-like substances.

Side Effects: Certain side effects of Priscoline—"crawling" cutaneous sensation, chilliness with resultant gooseflesh or feeling of warmth—indicate attainment of effective dosage level; occasionally tachycardia, tingling, nausea and epigastric distress, slight hypotensive effect or slight rise in blood pressure may be experienced.

AGE 75. Arteriosclerotic ulceration with erysipeloid reaction and marked inflammation; after administration of oral Priscoline, 25 mg. three times daily, for one week—increased thereafter to 50 mg. four times daily—there is steady improvement, healing in eight weeks. No other medication used.



Priscoline®

FOR COMPLETE INFORMATION on Priscoline ask your CIBA representative or write Medical Service Division, CIBA Pharmaceutical Products, Inc., Summit, N. J. **SUPPLIED:** Priscoline hydrochloride (tolazoline hydrochloride CIBA) is available as 25-mg. tablets (scored), bottles of 100 and 1000; elixir, 25 mg. per 4 ml., in pints; 10-ml. multiple-dose vials, 25 mg. per ml.

Photographs and accompanying clinical data by courtesy of R. I. Lowenberg, M.D., Consultant in Vascular Surgery, Connecticut State Hospital, Middletown, Connecticut.

AGE 68. Arteriosclerosis obliterans cellulitis; sluggish response to saline dressings and procaine penicillin 300,000 units daily; healing speeded by oral Priscoline, 25 mg. four times daily for one week, 25 mg. every three hours thereafter; healing within six weeks.



Wed. Morning, May 5

**LAST CHANCE TO VOTE — BALLOT BOX OPEN
UNTIL 10:30 A.M.**

8:25 JOINT SECTION ON SURGERY AND THORACIC DISEASES (All Physicians Invited)

Main Floor, Auditorium

PRESIDING:

Charles Watt, Thomasville

Discussion to be called for if time permits

8:25 ASSEMBLY

8:30 ANNOUNCEMENTS

8:35 INJURIES TO THE ANKLE

Wood Lovell, Atlanta

9:00 TECHNIQUE OF THYROIDECTOMY

A. H. Letton, Atlanta

9:20 PNEUMATOCELE OF THE GREATER OMENTUM
WITH GANGRENE

George T. Nicholson, Cornelia

9:35 VEIN STRIPPING

Morgan Kellum, Thomaston

9:50 GALL BLADDER DISEASE

Thomas N. Guffin, Atlanta

10:10 COIN LESIONS OF THE LUNG

Oscar Creech, Houston, Tex.

10:40 IMPORTANCE OF THE ORDINARY CHEST FILM
IN THE DIAGNOSIS OF MALIGNANT TUMORS
OF THE LUNG

Frank Berry, Washington, D. C.

11:10 ELECTION OF 1955 PROGRAM CHAIRMEN

11:15 VIEW EXHIBITS

11:00 ELECTION OF 1955 PROGRAM CHAIRMAN

11:05 VIEW EXHIBITS

11:30 JOINT SESSION ON MEDICINE AND SURGERY (All Physicians Invited)

Main Floor, Auditorium

PRESIDING:

William Harbin, Rome

11:30 SELECTIVE TREATMENT OF DIABETES MELLITUS
ACCORDING TO SEVERITY

Arthur Colwell, Chicago

12:15 SURGICAL MANAGEMENT OF THROMBOTIC
OCCLUSION OF THE ABDOMINAL AORTA AND
AORTIC ANEURYSMS

Oscar Creech, New Orleans, La.

Wed. Afternoon, May 5

2:00 THE WORK OF THE OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE (Health and Medical)

Frank Berry, Washington, D. C.

Walter Little Room, Dempsey Hotel

2:30 FINAL SESSION HOUSE OF DELEGATES

2:35 FINAL GENERAL SESSION (All Physicians Invited)

Walter Little Room, Dempsey Hotel

PRESIDING:

William Harbin, Rome

1. Presentation of 50 year certificates
2. Presentation of Hardeman Award
3. Presentation of Certificates of Appreciation
4. Presentation of Scientific Exhibit Awards
5. Golf Prize Awards
6. Presentation of President's Key
Thomas L. Ross, Macon
7. Selection of 1955 Annual Session meeting place
8. Announcements
9. Election results
10. Installation of new officers
11. Adjournment

3:30 NEW COUNCIL ORGANIZATIONAL MEETING

Walter Little Room, Dempsey Hotel

3:30 1955 ANNUAL SESSION PROGRAM COMMITTEE CHAIRMEN MEETING

Walter Little Room, Dempsey Hotel

**LAST CHANCE TO VOTE — BALLOT BOX
CLOSES 10:30 A.M.**

8:45 SECTION ON INTERNAL MEDICINE (All Physicians Invited)

Civic Room, Downstairs Auditorium

PRESIDING:

Mark S. Dougherty, Jr., Atlanta

Discussion to be called for if time permits

8:45 ASSEMBLY

8:55 ANNOUNCEMENTS

9:00 CRANIAL ARTERITIS

Haywood N. Hill, Atlanta

9:30 DIAGNOSTIC DUODENAL DRAINAGE

Napier Burson, Jr. and Kerrison Juniper,
Atlanta

10:00 CASE REPORT: UNUSUAL CASE OF CANCER
OF THE STOMACH

Hartwell Joiner, Gainesville

10:15 CASE REPORT: SALMONELLA PARATYPHOID B
IN THE GALLBLADDER

Sterling Claiborne, Atlanta

President's Invitation

1507 Saint Mary's Drive
Waycross, Georgia
April 1, 1954



TO THE MEMBERS OF the Auxiliary to the Medical Association of Georgia, and to those physicians' wives who are not members:

You are cordially invited to attend the Twenty-ninth annual meeting of the Woman's Auxiliary to the Medical Association of Georgia in Macon, May 2-5, 1954. The meetings will be held on the Mezzanine floor of the Hotel Dempsey.

Our hostesses, the members of the Auxiliary to the Bibb County Medical Society, have made delightful plans for your entertainment. Plan now to come to Macon for four days of inspiration and fellowship.

Cordially yours,

Mrs. Leo Smith

President Woman's Auxiliary
to the Medical Association of
Georgia

See You in Macon

Macon, Georgia
April 1, 1954

TO THE MEMBERS of the Woman's Auxiliary to the Medical Association of Georgia:

It is a pleasant privilege to extend to you, in behalf of the Woman's Auxiliary to the Bibb County Medical Society, a warm and sincere invitation to attend the Twenty-ninth Annual Meeting of the Woman's Auxiliary to the Medical Association of Georgia, which will be held in Macon, May 2-5, 1954.

Your visit with us will be an incentive for friendly relations, an interchange of ideas, and a better appreciation of our opportunity to promote health and freedom in the American way. It will be a happy occasion for our Auxiliary to be your hostess.

Our hospitality committees have completed some wonderful plans for your entertainment.



We are enthusiastic about your coming.
Sincerely,

Mrs. Willard R. Golsan

President, Woman's Auxiliary to
the Bibb County Medical Society

WOMAN'S AUXILIARY ORGANIZATION

Officers

President—Mrs. Leo Smith	Waycross
President-elect—Mrs. Shelley C. Davis	Atlanta
First Vice-President—Mrs. Robert C. Major	Augusta
Second Vice-President—Mrs. William K. Jordan	Macon
Third Vice-President—Mrs. Virgil B. Williams	Griffin
Recording Secretary—Mrs. W. P. Stoner	Sylvester
Corresponding Secretary—Mrs. H. A. Seaman	Waycross
Treasurer—Mrs. W. Loyd Osteen	Savannah
Historian—Mrs. T. A. Sappington	Thomaston
Parliamentarian—Mrs. Lee Howard, Sr.	Savannah

Advisory Committee

Dr. Ralph Chaney, <i>Chairman</i>	Augusta
Dr. Enoch Callaway	LaGrange
Dr. A. M. Phillips	Macon
Dr. W. F. Reavis	Waycross
Dr. C. F. Holton	Savannah

Standing Committee Chairmen

Achievement Award—Mrs. J. R. S. Mays	Macon
Archives—Mrs. C. W. Roberts	Atlanta
American Medical Education Fund— Mrs. W. P. Rhyne	Albany
Budget—Mrs. M. T. Edgerton	Atlanta
Civil Defense—Mrs. E. M. Dunstan	Decatur
Doctor's Day—Mrs. Waldo Floyd, Sr.	Statesboro
Editor, Auxiliary News—Mrs. Ted F. Leigh	Atlanta
Legislation—Mrs. Walker L. Curtis	College Park
Members-at-Large—Mrs. John Gallemore	Perry
Mental Health—Mrs. Edwin Allen	Milledgeville
Mrs. J. Bonar White Scrapbook Award— Mrs. O. T. Gower	Cordele
Nurse Recruitment—Mrs. T. E. Rogers, Jr.	Macon
Public Relations—Mrs. John E. Porter	Savannah
Research in Romance of Medicine— Mrs. Luther Wolfe	Columbus
Revisions—Mrs. W. G. Elliot	Cuthbert
Student Loan Fund—Mrs. William Boyd	Augusta
Mrs. James M. Brawner Trophy Award— Mrs. Ralph W. Fowler	Marietta

Presidents of County Auxiliaries

Baldwin—Mrs. James Baugh	Milledgeville
Bibb—Mrs. Willard R. Golsan	Macon
Bulloch-Candler-Evans—Mrs. Waldo Floyd, Sr.	Statesboro
Carroll-Douglas-Haralson—Mrs. E. V. Patrick	Carrollton
Chatham—Mrs. Harold M. Smith	Savannah
Chattooga—Mrs. W. U. Hyden	Trion
Cherokee-Pickens—Mrs. G. H. Perrow	Jasper
Cobb—Mrs. A. O. Colquitt, Jr.	Marietta
Coffee—Mrs. Roy Johnson	Douglas
Crisp—Mrs. Lee Williams, Jr.	Cordele
DeKalb—Mrs. John E. Beck	Decatur
Dougherty—Mrs. Frank Ward	Albany
Floyd—Mrs. Robert Black	Rome
Fulton—Mrs. E. A. Bancker	Atlanta
Glynn—Mrs. James Hicks	Brunswick
Gordon—Mrs. Byron H. Steele	Fairmount
Gwinnett—Mrs. N. H. Mason	Duluth
Habersham—Mrs. George Boyd	Clayton
Hall—Mrs. Eugene L. Ward	Gainesville
Jackson-Barrow—Mrs. A. B. Russell	Winder
Muscogee—Mrs. William Henderson	Columbus
Randolph-Terrell—Mrs. J. C. Patterson	Cuthbert
Richmond—Mrs. M. H. Wylie	Augusta
South Georgia—Mrs. D. L. Burns	Valdosta
Spalding—Mrs. Virgil B. Williams	Griffin
Stephens—Mrs. R. E. Shiflet	Toccoa
Sumter-Schley-Macon—Mrs. Frank Wilson	Leslie
Thomas—Mrs. Henry Pippin, Jr.	Thomasville
Tift—Mrs. W. L. Bridges, Jr.	Tifton
Tri-County—Mrs. W. C. Baxley	Blakely
Troup—Mrs. Ed Arnold	Hogansville
Upson—Mrs. D. L. Head, Jr.	Thomaston
Ware—Mrs. H. A. Seaman	Waycross
Washington—Mrs. Joseph E. Lever	Sandersville
Whitfield—Mrs. Lloyd Yeargin	Dalton
Worth—Mrs. J. L. Tracy	Sylvester

Special Committees

Camellia Garden—Mrs. R. W. Bradford	Milledgeville
Hall of Fame—Mrs. Olin S. Cofer	Atlanta

District Managers

First District—Mrs. L. H. Griffin	Claxton
Second District—Mrs. W. P. Stoner	Sylvester
Third District—Mrs. W. B. McMath	Americus
Fourth District—Mrs. Virgil B. Williams	Griffin
Fifth District—Mrs. Ben Hill Clifton	Atlanta
Sixth District—Mrs. William K. Jordan	Macon
Seventh District—Mrs. John McCall	Rome
Eighth District—Mrs. J. M. Hicks	Brunswick
Ninth District—Mrs. Paul Scroggins	Commerce
Tenth District—Mrs. Ralph Chaney	Augusta

Past Presidents and Conventions

Honorary Presidents for Life

Mrs. James N. Brawner, Sr., Atlanta

Mrs. Eustace A. Allen, Atlanta

1924—Augusta (Organization)—Mrs. C. W. Roberts, Atlanta, Temporary Chairman.

1925—Atlanta—Mrs. James N. Brawner, Sr., Atlanta

1926—Albany—Mrs. William H. Myers, Savannah

1927—Athens—Mrs. C. W. Roberts, Atlanta

1928—Savannah—Mrs. Paul Holiday (Mrs. J. C. Moore, Gaffney, S. C.)

1929—Macon—Mrs. Charles C. Hinton, Macon

1930—Augusta—Mrs. Marion T. Benson, Atlanta

1931—Macon—Mrs. Charles C. Harrold, Macon

1932—Savannah—Mrs. Ralston Lattimore, Savannah

1933—Macon—Mrs. S. T. R. Revell, Louisville

1934—Augusta—Mrs. J. Bonar White, Atlanta (Deceased)

1935—Atlanta—Mrs. J. E. Penland, Waycross

1936—Savannah—Mrs. Ernest R. Harris, Winder

1937—Macon—Mrs. W. R. Dancy, Savannah

1938—Augusta—Mrs. Ralph Chaney, Augusta

1939—Atlanta—Mrs. Warren A. Coleman, Eastman

1940—Savannah—Mrs. Eustace A. Allen, Atlanta

1941—Macon—Mrs. W. G. Banister, Rome

1942—Augusta—Mrs. Lee Howard, Savannah

1943—Atlanta—Mrs. J. Lon King, Macon

1944—Savannah—Mrs. Olin S. Cofer, Atlanta

1945—No convention

1946—Macon—Mrs. W. T. Randolph, Winder

1947—Augusta—Mrs. Bruce Schaefer, Toccoa

1948—Atlanta—Mrs. W. G. Elliott, Cuthbert

1949—Savannah—Mrs. S. A. Anderson, Atlanta

1950—Macon—Mrs. J. Harry Rogers, Atlanta

1951—Augusta—Mrs. Lehman W. Williams, Savannah

1952—Atlanta—Mrs. J. R. S. Mays, Macon

1953—Savannah—Mrs. Ralph W. Fowler, Marietta

Rules to Govern the Convention

1. The voting body of the convention shall consist of the members of the Executive Board of the Woman's Auxiliary to the Medical Association of Georgia and the duly accredited delegates from the county auxiliaries. No one is entitled to vote until registered.
2. To gain recognition, a delegate is requested to rise, address the chair, give her name and the name of her auxiliary.
3. No delegate shall speak more than twice on the same subject, and is limited to two minutes each time.
4. Badges must be worn by members of the voting body during all general sessions of the convention.
5. Delegates' privileges are not transferable.
6. All motions shall be presented in writing to the Recording Secretary. They shall be signed by the persons making and seconding the motion.
7. All original motions on resolutions shall be made by submitting two copies, one to the Resolutions Committee and one to the Recording Secretary.
8. All persons appearing on the program must be seated near the platform when the session opens.

Whispering conversations greatly retard the business of the meeting. Order must be maintained at all times. Please be prompt. Meetings will begin promptly at the time announced.

CONVENTION COMMITTEES

Woman's Auxiliary to the Bibb County Medical Society

General Chairman

Mrs. Milford B. Hatcher

Credentials and Registration

Mrs. W. Earl Lewis, *Chairman*

Mrs. C. Hall Farmer, *Co-Chairman*

Mrs. Frank Johnson	Mrs. Sam D. Work, Jr.
Mrs. J. T. Hogan, Jr.	Mrs. Charles T. Rumble
Mrs. R. W. Edenfield	Mrs. Leon J. Goodman
Mrs. J. Lon King, Jr.	Mrs. R. M. Reifler
Mrs. John Owen Martin	Mrs. Walter P. Barnes, Jr.
Mrs. Walter E. Mobley	Mrs. D. T. Henderson
Mrs. J. D. Applewhite	

Display and Meeting Room

Mrs. R. G. Ferrell, *Chairman*

Publicity

Mrs. J. C. Anderson, *Chairman*

Mrs. Holloway Bush

Memorial

Mrs. Harold C. Atkinson, *Chairman*

Decorations

Mrs. Leon D. Porch, *Chairman*

Mrs. W. C. Boswell, *Co-Chairman*

Mrs. Sam E. Patton	Mrs. J. D. Applewhite
Mrs. W. W. Baxley	Mrs. Hudnall G. Weaver
Mrs. Calder B. Clay, Jr.	Mrs. J. Fletcher Hanson
Mrs. William K. Jordan	Mrs. W. A. Williams

Transportation

Mrs. John Paul Jones, *Chairman*

Mrs. E. C. McMillan, Jr., *Co-Chairman*

Mrs. Rudolph W. Jones, Jr.	Mrs. A. R. Rozar
Mrs. R. W. McAllister	Mrs. Charles K. McLaughlin
Mrs. Charles L. Ridley, Jr.	Mrs. J. W. McFarlane
Mrs. John T. DuPree	Mrs. Edwin R. Watson
Mrs. Jule C. Neal	Mrs. H. M. Olnick
Mrs. George W. DuPree	Mrs. George A. Billingshurst
Mrs. Wallace L. Bazemore	

Timekeepers

Mrs. Charles C. Harrold Mrs. William K. Jordan

Pages: Auxiliary

Mrs. Edmund A. Brannen, *Chairman*

Mrs. Wm. W. Orr, *Co-chairman*

Mrs. Lynn Hicks	Mrs. Calder B. Clay, Jr.
Mrs. Richard B. Ewing	Mrs. John Owen Martin

Pages: Medical Society

Mrs. T. E. Rogers, Jr., *Chairman*

Mrs. B. W. Forester	Mrs. J. Lon King, Jr.
Mrs. Braswell E. Collins	Mrs. Holloway Bush
Mrs. Joe W. Daniels, Jr.	Mrs. Charles L. Ridley, Jr.
Mrs. Sam D. Work, Jr.	

Tickets: President's Dinner

Mrs. Edgar M. Pope, *Chairman*

Mrs. D. D. Walker, *Co-Chairman*

Mrs. William R. Birdsong	Mrs. Alvin E. Siegel
Mrs. W. C. Boswell	Mrs. Charles K. McLaughlin
Mrs. Roland A. Brown	Mrs. W. Devereaux Jarratt, Jr.
Mrs. George A. Billingshurst	Mrs. C. H. Richardson, Sr.
Mrs. Thomas Harrold	Mrs. John I. Hall
Mrs. J. B. Kay	

Buffet Supper

Mrs. J. R. S. Mays, *Chairman*

Mrs. C. H. Richardson, Jr., *Co-Chairman*

Mrs. Edwin R. Watson	Mrs. Leo J. Blum, Jr.
Mrs. Hudnall G. Weaver	Mrs. J. P. Woodhall
Mrs. Charles C. Hinton	Mrs. Frank Cary
Mrs. Charles J. Woods	Mrs. Ed Roe Stamps
Mrs. Braswell E. Collins	Mrs. O. O. Watson

Tea

Mrs. Frank M. Houser, *Chairman*

Mrs. Charles L. Ridley, Jr., *Co-Chairman*

Mrs. William K. Jordan	Mrs. Charles C. Harrold
Mrs. R. W. McAllister	Mrs. Walter F. Homeyer, Jr.
Mrs. O. R. Thompson	Mrs. Max Mass
Mrs. James A. Fountain	Mrs. J. L. King, Sr.
Mrs. William L. Barton	Mrs. Charles T. Rumble
Mrs. F. N. Aldrich	Mrs. William R. Birdsong

Luncheon

Mrs. A. M. Phillips, *Chairman*

Mrs. Sam E. Patton, *Co-Chairman*

Mrs. Thomas L. Ross, Jr.	Mrs. L. P. James
Mrs. Richard B. Ewing	Mrs. Jay Goldstein
Mrs. W. W. Baxley	Mrs. W. W. Chrisman
Mrs. R. C. Eberhardt	Mrs. O. F. Keen
Mrs. Lynn Hicks	Mrs. V. H. McMichael
Mrs. J. Emory Clay	Mrs. Roland A. Brown

President's Dinner

Mrs. Henry H. Tift, *Chairman*

Mrs. Charles J. Woods, *Co-Chairman*

Mrs. C. H. Richardson, Jr.	Mrs. C. H. Richardson, Sr.
Mrs. Ernest Corn	Mrs. W. A. Newman
Mrs. Holloway Bush	Mrs. J. Benham Stewart
Mrs. B. W. Forester	Mrs. W. Devereaux Jarratt, Jr.
Mrs. W. D. Hazlehurst	Mrs. Daniel E. Nathan
Mrs. Allen Smith	Mrs. William W. Orr
Mrs. Benjamin Bashinski	Mrs. Thomas Harrold
Mrs. R. Cullen Goolsby	

SPECIAL CONVENTION COMMITTEES

Audit

Mrs. Oscar Lott, Savannah

Mrs. John W. Daniel, Jr., Savannah

Courtesy

Mrs. D. L. Burns, Valdosta

Mrs. Lee Williams, Jr., Cordele

Mrs. George Nicholson, Jr., Cornelia

Resolutions

Mrs. Lester Harbin, Rome

Mrs. Alex Russell, Winder

Mrs. Harold M. Smith, Savannah

Exhibit

Mrs. Albert Rayle, Atlanta

Mrs. Maxwell Berry, Atlanta

Reading

Mrs. Lee Howard, Sr., Savannah

Mrs. M. H. Wylie, Augusta

Mrs. E. A. Bancker, Atlanta

Pledge of Loyalty

to the

Woman's Auxiliary

to the

Medical Association of Georgia

I pledge my loyalty and devotion to the Woman's Auxiliary to the Medical Association of Georgia. I will support its activities, protect its reputation, and ever sustain its high ideals.

Collect

"Keep us, O God, from pettiness; let us be large in thought, word and deed.

Let us be done with fault-finding and leave off selfseeking.

May we put away all pretense, and meet each other face to face without self-pity and without prejudice.

May we never be hasty in judgment, and always generous.

Let us take time for all things; make us to grow calm, serene, gentle.

Teach us to put into action our better impulses, straightforward and unafraid.

Grant that we may realize it is the little things that create differences; that in the big things of life we are one.

And may we strive to reach and to know the great common woman's heart of us all, and, O, Lord God, let us not forget to be kind."

TWENTY-NINTH ANNUAL CONVENTION **WOMAN'S AUXILIARY to the MEDICAL ASSOCIATION OF GEORGIA**

May 2, 3, 4, 5, 1954 Headquarters, Hotel Dempsey 515 Cherry Street, Macon

REGISTRATION — Mezzanine, Hotel Dempsey

Sunday
11:00 A.M. to 6:00 P.M.

Monday
9:00 A.M. to 4:30 P.M.

Tuesday
9:00 A.M. to 1:00 P.M.

PROGRAM AND ENTERTAINMENT

Sunday, May 2

12 Noon PRE-CONVENTION MEETING OF THE EXECUTIVE BOARD—DUTCH LUNCHEON
Civic Room, Hotel Dempsey

3:30 P.M. JOINT MEETING WITH THE MAG HOUSE OF DELEGATES

Main Floor, Auditorium

PRESIDING, William Harbin, MAG President, Rome

“MEDICAL ETHICS”

H. L. Pearson, AMA Judicial Council Member, Miami, Fla.

“ACTIVITIES OF THE AMA”

Walter Martin, AMA President-Elect, Norfolk, Va.

“WOMAN'S AUXILIARY”

Mrs. Leo Smith, Auxiliary President, Waycross

“BETTER HEALTH COUNCIL”

Mrs. Bruce Schaefer, Acting Chairman, Toccoa

4:30 P.M. JOINT MEMORIAL SERVICE WITH MAG
Main Floor, Auditorium

PRESIDING, William Harbin, MAG President, Rome

INVOCATION: Dr. Albert Grady Harris, Minister, First Presbyterian Church

SOLO: “One Sweetly Solemn Thought”

Miss Alice Ann Hamilton; accompanied by Mr. Crockett Odom

MEMORIAL SERVICE: Dr. Albert Grady Harris

IN MEMORIAM:

(1) MAG, J. Calvin Weaver, Atlanta

(2) Woman's Auxiliary, Mrs. Harold Atkinson, Macon

SOLO: “The Lord's Prayer”

William W. Orr, accompanied by Mr. Crockett Odom

6:30 P.M. SPECIAL BUFFET SUPPER SPONSORED BY THE WOMAN'S AUXILIARY TO BIBB MEDICAL SOCIETY (by Subscription only)
Walter Little Room, Hotel Dempsey

Monday, May 3

10:00 A.M. GENERAL MEETING

Civic Room, Hotel Dempsey

4 to 6 P.M. TEA

Home of Mrs. Frank M. Houser
1487 Waverland Drive

7:30 P.M. ALUMNI BANQUETS

Emory University School of Medicine
Pinebrook Inn, Rt. 41, Forsyth Rd.

Medical College of Georgia

Walter Little Room, Hotel Dempsey

Tulane University of Louisiana

Jeff Davis Room, Lanier Hotel

Tuesday, May 4

10:00 A.M. GENERAL MEETING

Civic Room Hotel Dempsey

1:00 P.M. LUNCHEON

Pinebrook Inn, Forsyth Road

6:00 P.M. SOCIAL HOUR (by Invitation)

Idle Hour Country Club

Compliments of Central of Georgia Railroad

By Subscription Only

Wednesday, May 5

9:00 A.M. POST CONVENTION BOARD MEETING, DUTCH BREAKFAST

PRESIDING: Mrs. Shelley C. Davis

Mirror Room, Hotel Dempsey

1:00 P.M. SPECIAL GUESTS LUNCHEON

(Honoring Guest Speakers)

By Subscription Only

Walter Little Room, Hotel Dempsey

2:00 P.M. “THE WORK OF THE OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE

(Health and Medical)

Frank Berry, Washington, D. C.

2:30 P.M. FINAL GENERAL SESSION

(Open to All Members)

PRESIDING: William Harbin, MAG

President, Rome

1. Presentation of 50-year certificates

2. Golf Prize Awards

3. Presentation of Certificates of Appreciation

4. Presentation of President's Key by Tom Ross, Macon

5. Scientific Exhibit Awards

6. Selection of 1955 Annual Meeting Place

Tickets available for: (1) Sunday Buffet Supper, Hotel Dempsey; (2) Tuesday's President's Dinner, Idle Hour Country Club and (3) Wednesday's special Guests Luncheon, Hotel Dempsey. Physicians wives are most cordially invited to attend these events. Dress optional.

7. Announcements
8. Election Results
9. Installation of New Officers
10. Adjournment

In Memoriam

Mrs. J. W. Dupree, Columbus
 Mrs. Clinton Reed, Atlanta
 Mrs. C. G. Redmond, Savannah

GENERAL MEETINGS

Hotel Dempsey, Civic Room

Monday, May 3, 10:00 A.M.

CALL TO ORDER BY THE PRESIDENT

Mrs. Leo Smith, Waycross

INVOCATION

Mrs. J. Lon King, Macon

PLEDGE OF LOYALTY

Mrs. Ralph Chaney, Augusta

WELCOME

Mrs. Willard R. Golsan, President, Woman's Auxiliary to the Bibb County Medical Society

RESPONSE

Mrs. C. J. Roper, Jasper

INTRODUCTION OF HONOR GUESTS AND PAST PRESIDENTS

Mrs. J. E. Penland, Waycross

PRESENTATION OF CONVENTION PLANS AND CHAIRMEN

Mrs. Milford B. Hatcher, Macon, General Chmn.

INTRODUCTION OF PAGES

Mrs. Edmund A. Brannen, Macon

REPORT OF THE ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY TO THE MEDICAL ASSOCIATION OF GEORGIA

Dr. Ralph Chaney, Augusta, Chairman

GREETINGS

Dr. William Harbin, President, Medical Association of Georgia

ADDRESS

Mrs. Mason G. Lawson, Little Rock, Arkansas, Treasurer, Auxiliary to the American Medical Association

Business Session

CONVENTION RULES OF ORDER

Mrs. Lee Howard, Sr., Savannah, Parliamentarian

ROLL CALL

Mrs. W. P. Stoner, Sylvester, Recording Secretary

MINUTES

STATEMENT OF TREASURER

Mrs. W. Loyd Osteen, Savannah

REPORT OF AUDITING COMMITTEE

RECOMMENDATIONS OF THE EXECUTIVE BOARD

REVISIONS TO THE CONSTITUTION AND BY-LAWS

Mrs. W. G. Elliot, Cuthbert, Revisions Chairman

REPORT OF CREDENTIALS COMMITTEE

Mrs. W. Earl Lewis, Macon

ADDRESS: Present Day Health Needs of Georgia

T. F. Sellers, Director, Georgia Department of Public Health

Tuesday, May 4, 10:00 A.M.

CALL TO ORDER BY THE PRESIDENT

Mrs. Leo Smith, Waycross

INVOCATION

Mrs. C. C. Harrold, Macon

PLEDGE OF LOYALTY

Mrs. Eustace A. Allen, Atlanta

INTRODUCTION OF PAGES

Mrs. Edmund A. Brannen, Macon

CONVENTION ANNOUNCEMENTS

Mrs. Milford B. Hatcher, Macon

PRESENTATION OF SOUTHERN MEDICAL ASSOCIATION

DOCTOR'S DAY AWARD

Mrs. W. G. Elliot, immediate past councillor, Auxiliary to the Southern Medical Association

ADDRESS

Mrs. George D. Feldner, New Orleans, Louisiana, President, Auxiliary to Southern Medical Association

PLANS FOR 1954-55

Dr. Peter B. Wright, Augusta, President-elect, Medical Association of Georgia

Business Session

ROLL CALL

MINUTES

REPORT OF CREDENTIALS COMMITTEE

Mrs. W. Earl Lewis, Macon

REPORT OF REVISIONS COMMITTEE

Mrs. W. G. Elliot, Cuthbert, Chairman

REPORT OF RESOLUTIONS COMMITTEE

Mrs. Lester Harbin, Rome

REPORT OF COURTESY COMMITTEE

Mrs. D. L. Burns, Valdosta

REPORT OF AWARDS COMMITTEE

Achievement—Mrs. J. R. S. Mays, Macon

Scrapbook—Mrs. O. T. Gower, Jr., Cordele

Browner Cup—Mrs. Ralph W. Fowler, Marietta

REPORT OF NOMINATING COMMITTEE

Mrs. M. T. Edgerton, Atlanta

ELECTION OF OFFICERS

INSTALLATION OF OFFICERS

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Bladder Neck Obstruction with Hypertension

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and C. A. FORT, M.D., Atlanta

THE DEVELOPMENT of hypertension with secondary cardiac damage as a result of lower urinary tract obstruction is an established fact. Maher and Wosika⁷ state that as long ago as 1877 Cohnheim reported cardiac hypertrophy in bilateral hindrance to urinary drainage caused by a large stone in the bladder. Passler in 1906, Brasch in 1911 and von Monatrow and Mayer in 1918 were others to record similar findings. In 1920 O'Connor⁸ noted a lowering of abnormally high blood pressures in 74 patients with urinary obstruction when satisfactory bladder drainage was effected. Using animals experimentally, Bell and Pedersen¹ in 1930 observed that complete blockage of the urinary tract caused a rise in blood pressure and that removal of this obstruction resulted in relief of this hypertension.

The mechanism of development of hypertension secondary to urinary obstruction is considered by some observers to depend on the so-called "back pressure" on the kidneys.⁶ With the kidneys unable to empty well because of a distended bladder, hydronephrosis develops with increase in intracalyceal pressure and decreased renal secretion occurs. It is then necessary for the heart to raise the arterial pressure to attempt to maintain urine secretions. Edward Campbell² believes this mechanism is especially significant in producing hypertension in patients with intrarenal pelves, because these can not dilate well and therefore the intracalyceal pressure is greater. This same

general process is possibly involved with bilateral obstructions above the bladder neck and also with any type of urethral blockage, as by stricture or urethral meatal stenosis.

When renal ischemia occurs as a result of hydronephrosis and increased intracalyceal pressure, Goldblatt⁴ believes that a pressor substance, renin, is liberated from the kidney into the blood stream. Hypertension then results from the effects of this substance. Goldblatt, in fact, believes that renal ischemia is the primary cause of nearly all forms of clinical hypertension.

The most common site of lower urinary tract obstruction is at the bladder outlet and the most frequent cause is benign hyperplasia of the prostate. In a study of 101 cases of hypertension associated with urinary pathology, Maher and Wosika⁷ found 72 cases of impediment to urinary flow. Thirty eight of these occurred at the vesical outlet, 31 of them being cases of benign prostatic hyperplasia. Carcinoma of the prostate may block not only the prostatic urethra but also the lower ureters by extension of the tumor into the seminal vesicular regions. Bladder tumors and calculi which prolapse into the outlet may cause chronic urinary retention and possible hypertension.

A not infrequent cause of bladder neck obstruction, *in an usually younger age group*, is median bar formation, often variously referred to as vesical neck fibromuscular hyperplasia, vesical neck fibrosis and contracture of the bladder neck. This pathological entity has been recognized since 1834 when Guthrie first described a median bar.

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A Study of Secondary Cardiac Damage from Lower Urinary Tract Obstruction

There was, however, little general knowledge of the subject until 1917 when Randall⁴ published his findings of an 18 per cent incidence of median bar in 300 adult male autopsy specimens. This condition may be congenital as well as acquired. Other less common, usually congenital, causes of urinary retention and possible hypertension are valves of the posterior urethra, hypertrophy of the verumontanum, urethral polypoidosis and tumors, ureteroceles prolapsing into the vesical neck,⁵ and hypertrophy of the interureteric ridge.

The significance of bladder neck obstruction in the older age group is well recognized, but in the medical, as distinguished from the urological, literature very little reference to these latter entities, especially to median bar, has been found. Since the systemic effects of this pathology, such as hypertension and renal insufficiency, may lead the patient to physicians other than urologists, the following case is recorded in detail to emphasize the possibility of vesical neck dysfunction in the relatively young. Of interest in this report are the dearth of urological symptoms and the reversible sequelae.

CASE REPORT

F. J. B., a 32-year-old unmarried white salesman, was admitted to the Medical Service of Lawson V. A. Hospital on November 21, 1949, with a chief complaint of increasingly severe, intermittent suboccipital and frontal headaches for three months. These were at first dull, later becoming throbbing and continuous. They lasted from a few hours to two days and occurred two or three times a week, being associated with nausea, vomiting and occasional epistaxis. Due to the nausea and vomiting he had ceased drinking alcohol three months prior to admission. For 6 or 8 years he had drunk 15 to 20 bottles of beer a day. During the four weeks prior to admission he had noted blurred vision, polydipsia and a craving for sweets. Quite incidentally he mentioned that for 6 to 8 months he had noticed some difficulty in initiating the urinary stream, that he voided only small amounts at a time, and that he had a diurnal frequency of 6 to 8 times and nocturia of 2 to 3 times. Further questioning revealed the complaint of mild urethral burning when he micturated, a frequently associated desire to defecate, and ability to void with less straining when he relaxed in the sitting position. He had also noted a swelling in the lower abdomen of two years' duration to which he had attached no significance. He denied other symptoms referable to the urinary tract.

The past history revealed gonorrheal urethritis four years previously, treated with penicillin intramuscularly every three hours for three days. Dosage was unknown.

Physical examination showed a chronically ill, mentally alert male with a blood pressure of 200/130 bilaterally. This dropped to 162/120 after one hour of rest. The eyegrounds revealed considerable caliber variation of the arterioles and overfilling of the venules. The AV ratio was 1:2. Numerous flame-shaped small round hemorrhages with a few whitish exudates were present. Some silver wire arteries were seen but there was no papilledema. A large dull mass rising to the umbilicus from the pelvis was palpable. Both kidneys were felt on deep inspiration and the liver edge was one



Fig. 1. Retrograde pyelogram made after azotemia had disappeared reveals residual bilateral mild hydronephrosis and ureterectasis. This pathology was probably greater before the urinary retention was relieved.

fingerbreadth below the costal margin. The rest of the physical examination, including the heart, lungs and nervous system, was entirely normal.

Urinalysis was normal except for a specific gravity of 1.007 and numerous WBC with occasional clumps. A PSP test done the day after catheter drainage was established showed five per cent excretion in two hours and a Fishberg concentration test demonstrated specific gravities of 1.010, 1.011 and 1.012. The NPN was 70, the urea nitrogen 37, the creatinine 3.6, and the inorganic phosphorus 5.2 milligrams per cent. The liver function, serology and fasting blood sugar tests were normal. Except for a hemoglobin of 10.1 grams and a sedimentation rate of 39 millimeters per hour, the CBC was normal. Urine culture revealed a heavy growth of mimeae. An EKG showed early ischemia of the heart muscle. The spinal fluid examination was normal as were chest and lumbar spine roentgenograms.

Urological consultation was obtained as the abdominal mass was considered to be bladder. Examination disclosed a normal sized, very tender, smooth, non-indurated prostate gland which had been flattened by a markedly dilated bladder. The right seminal vesicle was palpable. Urethral endoscopy revealed 1550 cc. grossly clear residual urine. The bladder neck demonstrated a definite median bar formation with marked elevation of this contracture above the trigone. The supramontine distance was only 1.5 cm., but the entire prostatic urethra was edematous. The verumontanum was slightly enlarged and shaggy and a few inflammatory polypi were present. The bladder showed coarse trabeculations with some cellulose formation, however, the interureteric ridge was not hypertrophied and no significant basal fund was observed. A diagnosis of median bar was established.

Continuous catheter drainage was started. Urine output ranged from 4000 to 5000 cc. daily, while fluid intake was

1000 to 5000 cc. The blood pressure, checked several times daily, gradually subsided and reached normal on the fourth day after the catheter was inserted. After that it remained normal, ranging from 120/80 to 138/90 during the rest of the hospitalization. By the eighth day the NPN was 65 milligrams per cent and the PSP results had improved to 18 per cent excretion in two hours. The eyeground hemorrhages were also noted to be clearing. Nine days later the NPN was 42 milligrams per cent.

Retrograde pyelograms were made after the azotemia had cleared. These demonstrated mild bilateral hydronephrosis (Fig. 1). This was probably greater before catheter drainage was established. A cystourethrogram illustrated elevation of the junction of the bladder neck and prostate posteriorly and narrowing of the bladder neck. (Fig. 2.)

In view of the absence of evidence of spinal cord pathology, a transurethral electroresection of the median bar was done. Approximately three grams of tissue was removed from the bladder neck. Pathological examination of this tissue showed smooth muscle, fibrous tissue and hyperplastic cuboidal epithelium. Diagnosis was fibromuscular hyperplasia.

The postoperative course was benign. The patient voided well with an excellent stream after the catheter was removed on the third day. By the 15th day residual urine was only 10 to 15 cc. and the ophthalmologist found remarkable improvement in the appearance of the fundi. No hemorrhages or exudates were present but there were still some wide reflex streaks along the arteries and some caliber variations. The patient himself noted no headaches for three weeks but he complained of residual mild blurring of vision when reading.

The patient was rechecked in February, 1950. He was voiding well without nocturia and had 30 cc. residual urine. His weight had increased ten pounds. There was no blurring of vision. The blood pressure was 140/80 without rest.

Further checkups were made in April, 1950, January, 1951, November, 1951, and December, 1952. Blood pressure ranged from 136/80 to 124/78. The eyegrounds were each time completely normal and the patient was asymptomatic. No residual urine was present. There was a total weight gain of twenty pounds.



Fig. 2. Cystourethrogram illustrates the narrowed bladder neck and the anterior angulation of the prostatic urethra, both resulting from the presence of the median bar.

Discussion

This case, as stated previously, is presented principally because it serves to emphasize the possible systemic effects of a bladder neck obstruction in a young age group. This patient, rather typically, sought medical advice because of his systemic sequelae rather than because of his urological symptoms. The frequently insidious onset of these latter complaints causes the patient to accept them as being relatively benign.

Vesical neck pathology may be, to repeat, congenital or acquired. This case could have been either since, more often than is realized, congenital obstructions may not become symptomatic until later in life. Campbell² recorded an autopsy on a 72-year-old male who died of obstructive uropathy and sepsis secondary to a congenital valve in the posterior urethra. The probable cause of congenital median bars is neuromuscular dysfunction.³ In the acquired type, chronic infection of the prostate and posterior urethra apparently is the initiating factor.¹⁰ Prostatitis may cause obliteration of the submucosal glands with resultant fibrous displacement of the muscle fibers at the bladder neck. When contraction of this fibrous tissue occurs, the median bar is formed. Other causes of this entity are excessive and frequent masturbation and even possibly excessive fluid intake.

Obstruction of the vesical outlet is not, of course, limited to males. More and more frequently transurethral electroresection of the bladder neck is being practiced in females. Cases which formerly were diagnosed as chronic urethritis or cystitis are often now subjected to surgery when indicated. Apparently the histopathology in male and female vesical neck contracture is the same, showing hypertrophy of smooth muscle, fibrosis and chronic inflammatory changes.

In children, vesical neck pathology should be suspected when enuresis, frequency, nocturia, recurrent pyuria, dribbling, dysuria, urgency or retarded growth with any of these other symptoms is present.

Too often bladder neck obstruction is not discovered early enough to prevent irreparable damage to the upper urinary tract, with resultant renal insufficiency and possible hypertension.

Summary

A case of median bar is presented to emphasize the possibility of any bilateral blockage of the renal urinary flow as a cause of renal insufficiency and secondary cardiac and hypertensive changes.

Some of the more important theories concerning the mechanism of development of hypertension in patients with urinary obstruction are enumerated.

Bladder neck obstruction may occur in the child and the young adult, male or female, as well as in the older age group. The various types of lower urinary tract obstruction, congenital and acquired, are recorded.

It is suggested that, in any case of hypertension or renal insufficiency, obstructive uropathy should be ruled out by determination of residual bladder urine and by excretory urography if there is no azotemia. If azotemia is present, retrograde pyelography then would be indicated.

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Resolution on the Death of John William Daniel

ON JANUARY 1, 1954, Dr. John William Daniel passed to his eternal reward. Dr. Daniel was born in Burke County Georgia on September 25, 1868, and at the time of his death was slightly over eighty-five years old. He attended the Richmond Academy in Augusta, Georgia, for his high school education and graduated at the University of Georgia in 1888. His medical degree was given by the Medical College of Georgia in 1896 and at the time of his death he had practiced in Savannah for over fifty-seven years.

He received many medical honors. In 1927 he was given the A.O.A. key and in 1923 his fellow practitioners of Georgia elected him as president of the Medical Association of Georgia which office he filled faithfully and well until 1924.

He was always interested in civic affairs and served as a city alderman for several terms. During World War One he volunteered his services and was discharged as a Major in the Medical Corps. He was a 32nd degree Mason.

Dr. Daniel was always vitally interested in metabolic diseases and wrote many articles for publication about those conditions. He was the first doctor in Savannah to use insulin and was one of sixty physicians in the United States to give clinical tests to that preparation when it was first originated.

Dr. Daniel was a firm disciple of Hippocrates. His every thought was for his fellow man and no patient was too poor or forlorn to command his interest and secure his services. He was uniformly kind and courteous to his contemporaries in the practice of medicine and to the young men he was an unfailing inspiration and source of learning. He never refused a consultation and never failed to discuss the case completely and clearly with the physician who called him.

By his gentleness and consideration he endeared himself to thousands of patients and those of us who knew him well will miss his courtly demeanor and kindly advice.

THEREFORE be it RESOLVED that the Georgia Medical Society in regular meeting assembled express its profound regrets at the passing of one of our most honorable members and

RESOLVED that a page of the minutes of this society be set aside in memory of Dr. John William Daniel

And That a copy of this resolution be furnished to the bereaved members of Dr. Daniel's family and

That a copy be forwarded to the Secretary of the Medical Association of Georgia.

Signed:

C. F. Holton

J. K. Quattlebaum

J. C. O'Neill

Symposium on Lung Cancer

M. BEDFORD DAVIS, JR., M.D., Atlanta, Ga.

THIS PAPER IS a report of the two-day Seminar on Lung Cancer which was sponsored by the American Cancer Society as a part of its annual meeting in New York in November, 1953. All aspects of the subject were considered and many of the nation's foremost authorities presented papers on both the scientific and clinical sides of the problem.

Whenever mention is made of the apparent meteoric rise in the incidence of cancer of the lung, there are those who state that the increased number of cases is the result of better diagnosis. It is well known that statistics can be shuffled about so as to prove almost anything, but it is hard to conceive that at least part of the 2500 per cent rise in the death rate of the male population in the United States since 1914 from carcinoma of the lung is due to other than an actual rise in the incidence of the disease.

There are four and one half times as many cases in males now as in females, while in 1914 the rate was only 17 per cent higher in the male. A graph of this rate of increase in the male shows a very high spike, which now strangely enough has been dropping rapidly for the past four years. Twenty thousand persons in the United States died of diagnosed cancer of the lung in 1950, the last year for which statistics are available. Carcinoma of the stomach is the only malignancy in the male which outrates lung cancer as a cause of death.

In these statistical studies several other interesting facts stand out. The urban male population suffers from this disease 2.5 times as often as the rural male population, while the ratio of cases among these two groups of females remains 1:1.

Also there is no increase in the rate among males under 35 years of age.

Throughout the world there is a wide variation in the incidence of lung cancer. England has a rate which is between four and five times that in the United States. Austria has approximately 25 per cent more cases than England, while Italy, which adjoins Austria on one side, has less than one death per 100,000 population each year according to the figures presented. Japan has an extremely low rate, as does Siam and India. In the Belgian Congo it is almost unheard of in the native population.

Obviously some of these variations are due to lack of medical facilities in the areas mentioned. However such would seem unlikely in such countries as Italy and Austria. No explanation is offered for this inconsistency. Closer to home, it was pointed out that New Orleans has about three cases of lung cancer for each case in Atlanta. The figure given for Atlanta, however, would allow us only about 24 cases a year for the metropolitan area, which I am sure is many times lower than the actual incidence.

Whether racial and genetic differences are partly responsible for such differences can be a matter only for speculation at this time, because we have no studies which shed light on this problem. There do seem to be more cases among the white than non-white population, but no genetic differences in the races regarding susceptibility have been proven. We know that strains of mice can be bred which will develop lung cancer in about 90 per cent spontaneously, but no transfer of this data to humans can be made.

Report of a Symposium at the American Cancer Society Annual Meeting

Recently the newspapers have been filled with articles discussing the etiology of carcinoma of the lung. Most of these are based on the reports given at this meeting. Of course the role of tobacco led the items discussed. Dr. Ernest Wynder of Memorial Hospital presented a very convincing discussion pointing out that, on the basis of his studies and those of Doll and Hill in England, there is no doubt that smoking cigarettes causes cancer of the lung.

This idea was first voiced as early as 1912. Dr. Evarts Graham and Dr. Alton Ochsner have been the two leading champions in this country. In a study of 4500 cases, chain smokers were three times as common as more moderate smokers. In the cancer group nonsmokers numbered from .5 to 3.5 per cent, while in a control group nonsmokers constituted 10-18 per cent. Eighty-five per cent of the cases of smokers with cancer had smoked 30-35 years. These figures do not apply to adenocarcinoma. Finally in a laboratory study a condensate was made from 250 cigarettes which consisted chiefly of tobacco tar. This was applied to mice daily for long periods of time. The first cancer was produced in 12 months. Within two years 59 per cent of the mice so treated developed papillomas of the skin and 47 per cent of lesions eventually became carcinomas.

It is interesting to note that the tar extracted from the tobacco contained no benzpyrene or arsenic or other known carcinogen in quantity. He concluded actually with a statement that in such an important problem as lung cancer any possible etiologic factor must be considered and studied to the utmost. Until an exact evaluation of the role of tobacco can be made, he recommended moderation in smoking and requested cooperation from the tobacco companies in the identification and removal of carcinogens in tobacco.

Dr. Ochsner in discussing the subject of tobacco made the statement that—"if something is not done (about the smoking problem) in 50 years the entire male population will be decimated."

Dr. Hammond, of the American Cancer Institute, pointed out that in addition to tobacco, we must search the products of auto exhausts and industrial air pollution as possible etiological agents. Our methods of study have been faulty because they are all based on a study of statistics, which can be made to prove anything. He pro-

posed a substitute "forward method" for this so-called "backward method", consisting of a study of thousands of persons for a number of years. Admittedly this is a very costly and time consuming method. Nevertheless such projects are under way involving as many as 200,000 persons as subjects.

Hammond also presented the question of condemning tobacco and stopping the sale of cigarettes. In Denmark, for instance, 60 per cent of the national budget is supported by the tax derived from the sale of tobacco. In this country the tobacco companies furnish an amount in taxes which exceeds the amount spent on all forms of public health. If this source of income is suddenly cut off, some substitute must be forthcoming.

In rebuttal on the tobacco controversy, Dr. Alexander Gilliam, of the National Cancer Institute, pointed out that the marked increase in cancer of the lung, which followed World War I, came much sooner than would be expected from what is known about tobacco. In refuting the statistical studies given, he presented some of his own, "proving a brown-eyed person was more susceptible to lung cancer and so was one who was married."

Under the direction of the University of Southern California, extensive studies are under way in Los Angeles to determine what part, if any, is played in the pollution of air by industrial wastes and the exhausts of internal combustion engines. The samples of air being analyzed are as large as 2,000,000 cu. ft. In addition, exhaust gases were collected directly from engine exhaust pipes, varying under conditions of speed and load. A number of cyclic hydrocarbons, known to be carcinogenic, such as dibenzanthracene, have been identified. Two carcinogenic substances collected have not been definitely identified.

It is interesting that slow speeds and low engine loads are associated with higher rates of production, while at 80 mph an automobile engine puts out only negligible quantities of carcinogens. It has been discovered also that in industrial wastes dumped into the air, the carcinogens are absorbed on soot and are rendered impotent so long as this physical state remains. It is being postulated that somewhere there exists, probably in the lungs, a diluent which separates the carcinogens from the soot and thus renders them active again.

Study of any disease is facilitated by the ability to induce it in a laboratory animal. Naturally this

field has not been neglected in its relation to lung cancer. The mouse, rat, and guinea pig all have been used. Cancers can be produced by the cyclic hydrocarbons, azo dyes, urethane, nitrogen mustards and x-radiation. The substances have been administered subcutaneously, intravenously, intraperitoneally, and orally. Urethane produces a tumor specific for lung and azotoluene injected subcutaneously at the base of the tail will produce a tumor of the lung. Occasionally the exposure can be very brief in contrast to the familiar prolonged painting on of carcinogens before a tumor is produced. Urethane, for instance, injected intravenously into the mother in the last twenty-four hours of gestation will produce lung tumors in the offspring.

Dr. Harry Greene of Yale told of his work in combining tissue from half term embryos with carcinogenic agents and implanting the material in various sites of host animals. Malignant tumors are produced in a very high percentage of instances, he has tested tobacco, asbestos, and beryllium as carcinogens and has been unable to produce any tumors. He reminded us that none of the lung tumors he was able to produce are similar to human bronchogenic carcinoma. In fact, all the investigators made the same statement. There apparently does not exist in the laboratory animal a tumor corresponding to this lesion in man.

All of the above discussion has been more or less in the realm of the hypothesis, but we do have a few instances in which the cause of lung cancer has been traced out, and in some instances eliminated in certain industries. These apply, of course, to very small groups and hence are of little importance in the overall picture. For many years the role of radioactive material in the uranium mines in Europe in causing lung cancer has been known. Around 1921, a study was made in the copper smelting industry which led to the identification of arsenic as a similar offender. The process was revised, and since the incidence of cancer of the lung in these workers, over the general population, has practically disappeared.

In the chromate industry, it was found that 63 per cent of the deaths among the workers was due to carcinoma of the respiratory system. Certain crude acids used in processing were found to be responsible and again success was achieved by simply using refined acid. In the asbestos indus-

try 13.2 per cent of workers with asbestosis developed carcinoma of the lung while the general population had a rate of 1.32 per cent. The latent period was 16.5 years. In a similar group studied with silicosis, there was no increase in lung cancer over the rate for the general population.

On the more practical side of the problem of lung cancer is the detection of cases. It is well known that by far the majority of cases reach the surgeon too late for curative surgery. Mass x-ray surveys are being considered as a possible means of improving case finding. The large surveys to date have been made with the chief aim of uncovering tuberculosis, but results in cancer detection were surprising.

In Denver, it was discovered that the cancer rate was exactly three times the suspected rate. In 1950, 2,000,000 mass survey films were made in the United States; 64,000 were asked for a re-check and 55,000 returned for additional films; 14,000 were negative; 9,000 revealed old tuberculosis; 18,000 were active tuberculosis cases; 3,500 were tumor suspects; 340 were proven neoplasm; 62 refused treatment; 175 were lost to follow-up; 111 finally came to surgery. Of these, 84 were resected. Forty three were dead at this time. In Philadelphia, a smaller group, which has been followed for five years, presents only a 2 per cent survivor group. Obviously this is not an impressive result.

It is pointed out that these surveys were not designed to detect lung cancers, but tuberculosis. Most of the persons x-rayed were therefore young, and most females. The cost per case of tumor discovered can be cut by surveying the male population between 40 and 50 years of age. Better education of both the lay population and the medical profession is also necessary, because the average time between x-ray and operation is almost three months.

Another important change in a survey to find cancer is that the films must be repeated in order to detect changes, which in a single film might be considered insignificant. Numbers of incidents were demonstrated in which a comparison with previous films would have allowed a diagnosis at least six months before it was actually made. Dr. Overholt made a plea for earlier surgery after the lesions were discovered and showed a five year cure rate of nearly 75 per cent in the asymptomatic cases which underwent surgery within a week after finding the lesion.

Another discouraging feature of mass surveys is that in some series studied, half of the neoplasms were overlooked. The psychological state of the examiner was blamed and not the failure of the film to present the lesion. A plea was made for the addition of an enthusiastic young thoracic surgeon to the examiners or some other method of raising the index of suspicion among the radiologists.

Nevertheless, the x-ray film is often at fault. Many early neoplasms, especially those of the superior sulcus elude detection until symptoms of invasion of other structures lead to the diagnosis. This is due to the tumors' being concealed in the mediastinum or near the chest wall, where all the structures are of approximately the same density.

At the University of Pennsylvania, supervoltage x-ray is being studied as a possible means of finding these tumors. Films are made at 2,000 KV. The amperage is quite low. Exposures of two seconds are necessary to make the chest plate, and the patient receives a dose of 0.8 R units x-ray. These are obviously disadvantages. On the other hand, the bronchial tree is outlined well enough to allow discovery of intrabronchial tumors which have produced no atelectasis or pneumonitis. The detail within the lung fields and the mediastinum and the chest wall all show on the same film. With ordinary x-rays at least two films are necessary.

When a suspected case is discovered, a proven diagnosis is desirable. Dr. Herbut, of Jefferson Medical College, was quite enthusiastic over cytologic diagnosis. He made the statement that 85.6 per cent of their positive cases were diagnosed by this method as compared with 30.6 per cent positive cases by bronchoscopic diagnosis. The chief stress was placed on early thoracotomy, however, with or without a proven diagnosis. Dr. Rienhoff pointed out that this operation is no longer regarded as a form of euthanasia. Bronchoscopy is negative in 50 per cent or more of cases studied, and indeed is more likely to be considered a poor prognostic sign in most cases. Cytologic studies are almost useless in the general run of hospitals over the country. The mortality from surgery is almost nil in simple exploration. There are always the cases diagnosed as Virus Pneumonitis, which may or may not be such.

To prevent too long delay before surgery, Dr. Cahan, of Memorial, makes this recommendation to the general practitioner. In a patient with severe respiratory illness, x-ray in seven days. If then, there is not immediate improvement, wait no longer than 14 days to repeat the film if pneumonitis or atelectasis were found on the first film. If there is no improvement, the patient should be referred to a chest surgeon. If there has been clearing, but not complete resolution on the second film, repeat the x-ray in two weeks. Absence of complete clearing at this time is again an indication for surgical intervention.

The meeting terminated with a discussion of the biological and pathological aspects of cancer of the lung. Dr. Graham repeated his idea, which is generally accepted, that there are several types of cancer of the lung which are entirely different diseases. The multiple foci of origin of these tumors as a possible factor in the failure of the surgical therapy in at least some cases, was discussed by Dr. Ackerman, of Washington University. The old question of the existence of alveolar cell carcinoma of the lung was discussed as it has been so many times before.

Discussion of therapy brought about nothing really new. Dr. Churchill described "radical lobectomy" for upper lobe carcinoma and felt it was an adequate operation for certain upper lobe tumors. It consists of a lobectomy, plus block resection of the mediastinal lymphatic system. Radical pneumonectomy was discussed. Neither of these operations is old enough for proper evaluation; so we do not know where they will finally be catalogued in our armamentarium.

Dr. Ochsner reported his "palliative" cases, in which resection was not considered curative at the time of surgery. He stated that 6.6 per cent of these patients are alive at the end of five years. Supervoltage x-ray was presented as an improvement over routine methods. Of the many chemotherapeutic agents being tried, Methyl bis amine HCL was the only one which seemed worthwhile. Several five year survivals were reported in cases treated with this drug alone.

This two-day discussion was an excellent review of the present status of our knowledge of the problem. Most of the important problems remain unsolved, but certainly it is comforting to know that so much effort is being expended to discover the answers.

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Radiotherapy in Bronchogenic

Carcinoma

PRIMARY LUNG CANCER has been increasing in interest and clinical importance over the past 30 years. Most workers agree that the incidence of this particular cancer is on the increase and that it has been increasing disproportionately fast among males. Although there may be some causal relation to chronic heavy cigarette smoking in susceptible individuals at a critical age period, other factors such as exhaust fumes and other types of air pollution may be important.

Whatever the true cause for this increase may be, lung cancer comprises from 5 to 10 per cent of all neoplasms found at autopsy, and it kills from 15,000 to 18,000 Americans annually. The ratio of males to females is somewhere between 4 or 5 to 1. Four-fifths of the patients are over 40 years of age and the greatest incidence is in the fifties.

The majority (approximately 85 per cent) of these cancers are squamous cell epitheliomas. This is the type which afflicts males from 10 to 20 times more frequently than females and which may bear an etiologic relationship to excessive cigarette smoking. This type is usually slower growing than adenocarcinoma. The adenocarcinoma is generally more peripherally located and its incidence is about equally divided between males and females.

Primary pulmonary carcinoma frequently metastasizes early to the regional bronchopulmonary, tracheobronchial or paratracheal lymph nodes, in that order. It is often a silent primary source with metastases to the brain which makes it behave like a brain tumor. Besides the central nervous system and the bones, the liver and opposite lung are frequent sites of metastases from this tumor. From there it may spread to any part of the body.

The most hopeful means of cure of this disease lies in radical surgery, whether lobectomy or pneumonectomy. Even so, the survival rates are not impressive.

Read before a meeting of the Georgia Division, American Cancer Society, January 16, 1954 at Atlanta.

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HAROLD W. JACOX, M.D., New York

Dr. Richmond Moore reviewed 370 case records from the Presbyterian Hospital in New York City for a 10 year period from 1940 through 1949. Eighty-seven (or 23.5 per cent) underwent resection. Of the 31 patients resected prior to 1946, four were alive in 1950, or a 13 per cent five year survival rate of those resected and an overall five year survival rate of only 3 per cent. Other writers have reported similar results.

There are many workers who stress the importance of radiotherapy both as attempted curative and palliative measures. Some believe that the higher the dose the longer will be the survival time. The patients who receive a higher dose are generally in better initial condition than the others and therefore might have survived longer even without radiotherapy. It has not been proved that a higher dose will necessarily produce longer survival.

Most radiotherapists have had patients in whom clinical, radiographic and even bronchoscopic evidence of neoplasm disappeared for a time after roentgen therapy, but in whom recurrence or metastasis eventually developed. In general the smaller the tumor and the greater the "dose" of radiation applied to it, the more likely is the result to be good.

Only a few patients in whom a cure is hoped for are referred for radiotherapy. The majority are subjected to surgery, which is as it should be. Since so many patients who are referred for curative irradiation are considered unfit for surgery, the radiotherapist is at a disadvantage from the beginning.

If radiotherapy has so far had rather discouraging results when used as a means of cure, it has far more value as a palliative measure, the most effective for symptomatic relief. Cough, expectoration, hemoptysis, pain and dyspnea may all be relieved in varying degrees by radiation.

Also hilar, mediastinal and peripheral lymph nodes may be reduced in size; a superior vena caval compression syndrome may be relieved; obstructive pneumonitis may be resolved; parenchymal infiltration may be diminished; pathologic neoplastic fractures may be healed, and a feeling of well-being may be established. This is similar to what happens in many other conditions, such as cardiovascular, renal and neuropsychiatric disorders where only palliative management can occur.

In every case in which it is found that the tumor is not resectable or in which the patient refuses operation, roentgen therapy should be given a thorough trial. When giving roentgen therapy, the tumor should be localized radiographically and bronchoscopically so that the cross-fire technic may be accurate. The thoracic surgeon can be of great help if at exploration he will place metal clips in the periphery of the tumor and in the region of its metastases. In some small tumors attached to vital structures, such as the aorta or the pericardium, radon seeds placed at exploration may serve a useful purpose in retarding local growth until distant metastasis usually occurs.

Radiosensitivity as judged from a biopsy specimen alone is a dangerous thing and therefore full tolerance doses are usually indicated in any tumor. There is no way at present to tell what the response of any particular tumor will be so that if a patient is worth treating at all he should be given all the tissues will stand.

Although the heart can withstand huge doses, and I have never seen any damage to it, the lungs and pleura are more radiosensitive and they are the limiting factors. I have seen many patients die from cancer, but none from radiation pulmonary fibrosis which often produces only a minor incapacity and can be relieved by full doses of cortisone. It is only occasionally that we use a "test of irradiation" any longer in solitary intrathoracic tumors because exploratory thoracotomy can be done with very little risk and a definitive diagnosis will be made so that more accurate radiotherapy may be given.

Technical factors of treatment will not be discussed in detail, but it should be mentioned that there are 2 schools of thought—one which believes in only one intensive course of daily fractional treatments over a period of four or five weeks, while the other uses repetitive series of shorter courses and lesser total doses at two to

three month intervals. There is no readily demonstrable difference in the end results of these two methods.

However, in a group of 125 patients from the Mayo Clinic, in whom neither roentgen therapy nor operation was employed (a control group, if you will) none of them lived longer than one year after the diagnosis was made. In another group of 125 inoperable patients treated with only x-rays, 25 patients lived one to 12 years after the diagnosis. The value of roentgen therapy as a palliative measure in this group of 250 patients with proved primary bronchogenic carcinoma is self-evident.

As to the newer methods of treatment with higher radiation energies such as multi-million volt x-ray machines or cobalt beam therapy either with or without rotation of the patient or source, we have found no increase in cures from them. They allow larger doses to be given more easily for both the radiotherapist and for the patient, but, whereas the palliation may be greater, the end results are about the same as with the conventional voltage range and methods.

There are no radioactive isotopes that have any specific action on bronchogenic cancer, and there are none that have any lasting effect on this disease. The use of radioactive gold to reduce the accumulation of pleural fluid due to pleural metastases may be a valuable palliative procedure in some patients.

Nitrogen mustard (HN_2) does have some retarding effect on poorly differentiated or oat cell carcinoma of the lung. Biologically and histologically its cytotoxic effects are similar to radiation changes and sometimes the two have been used to complement each other. So far as I know this combination is not curative either, and may seriously depress the bone marrow.

In summary then, the treatment of choice for lung cancer is complete surgical extirpation which offers the patient the best chance of a cure. If this is impossible and the tumor is small but in a non-resectable position, radon seeds should be implanted at surgery. If it is a large tumor or with extensive regional metastases, intensive roentgen therapy should be given to the limit of tissue tolerance, cross-firing the lesion through multiple portals of entry in a single course of treatment.

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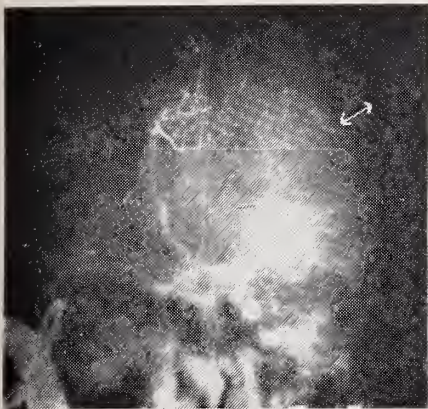


Fig. 1. Chronic subdural hematoma depressing middle cerebral artery complex away from inner table of skull. The anterior cerebral artery is shifted across the midline.



Fig. 2. Capillary phase of arteriogram showing dye concentrated in a glioblastoma located in the left parietal lobe.

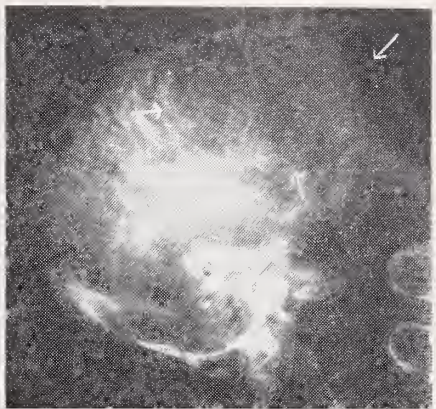


Fig. 3. Late arterial phase of arteriogram precisely outlining the bed of a large frontal lobe meningioma.

Cerebral Arteriography

LOUIS O. J. MANGANIELLO, M.D., and POMEROY NICHOLS, JR., M.D., Augusta, Ga.

IN THE PAST HALF century two outstanding procedures have been devised for the diagnosis and visualization of intracranial disease. The first of these was the introduction of pneumoencephalography by Dandy in 1918, followed 8 years later by Moniz¹ with cerebral arteriography.

The scope of carotid arteriography was originally intended for and limited to the investigation of vascular lesions of the brain. With continued use it was found to be of great value in the diagnosis and localization of brain neoplasms, even to a knowledge of tumor cell type. Similarly, cerebral thrombosis, cerebral abscess, degenerative diseases, and hematomas in an intracerebral, subdural or extradural location, are easily visualized. The use of cerebral arteriography in selected cases has been found to be safer, and for precise localization, superior to pneumoencephalography or ventriculography. Arteriography does not disturb the intracranial pressure differentials which is highly desirable in cases of expanding brain lesions.

This paper will serve to illustrate the range of diagnostic possibilities of carotid arteriography together with the use of a new contrast medium.

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The medium employed in the past 100 arteriograms has been 30 per cent Urokon Sodium.² One case of transient hemiplegia has been the only complication. It is felt that the lower incidence of side reactions plus the better x-ray contrast is an improvement over 35 per cent Diodrast.

The artist's drawing shows the proper positioning of the patient for insertion of the 16 gauge needle into the common carotid artery. The injection of dye is done after the table is lowered and the neck acutely flexed.

Figures 1 through 10 are a representative selection of arteriograms which best illustrate the precise information which can be obtained by this method of diagnosis.

Summary

1. A series of arteriograms representing brain tumors, aneurysms, thromboses, and hematomas are presented.
2. The employment of a new contrast medium is described.
3. The technic of injection is illustrated.

University Hospital

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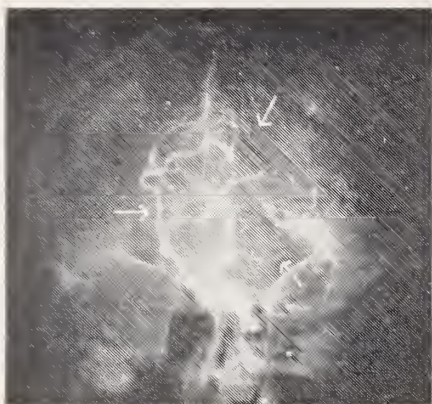


Fig. 4. Same case as Fig. 3. Arterial phase showing massive shift of anterior cerebral artery characteristic of tumors in this location.

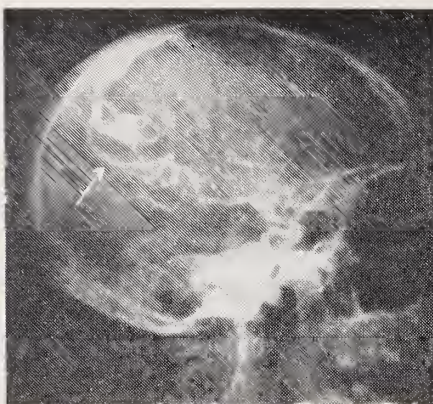


Fig. 5. Arterio-venous malformation in the right posterior parietal lobe showing the small arterial feeder coming in inferiorly and the large venous outlet going up to the superior longitudinal sinus.

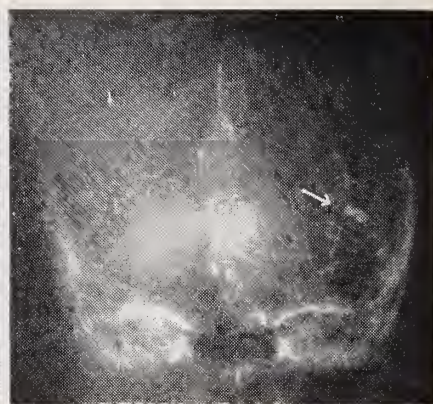


Fig. 6. Mycotic aneurysm on the middle cerebral artery in a case of subacute bacterial endocarditis. The aneurysm had ruptured producing an intracerebral hematoma, evidenced by the slight shift of the anterior cerebral artery to the opposite side.

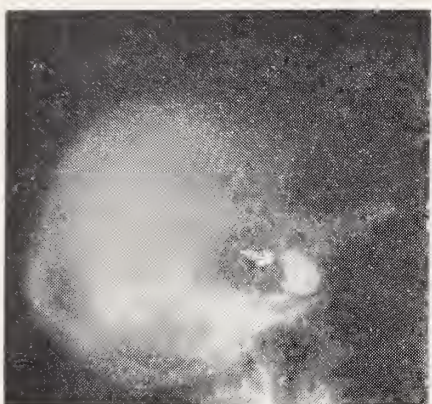


Fig. 7. Large congenital aneurysm of the internal carotid artery in a pre-rupture stage.

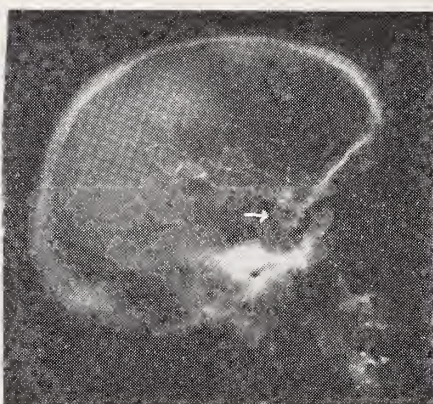


Fig. 8. Vestigial aneurysm of the internal carotid artery projecting posteriorly.



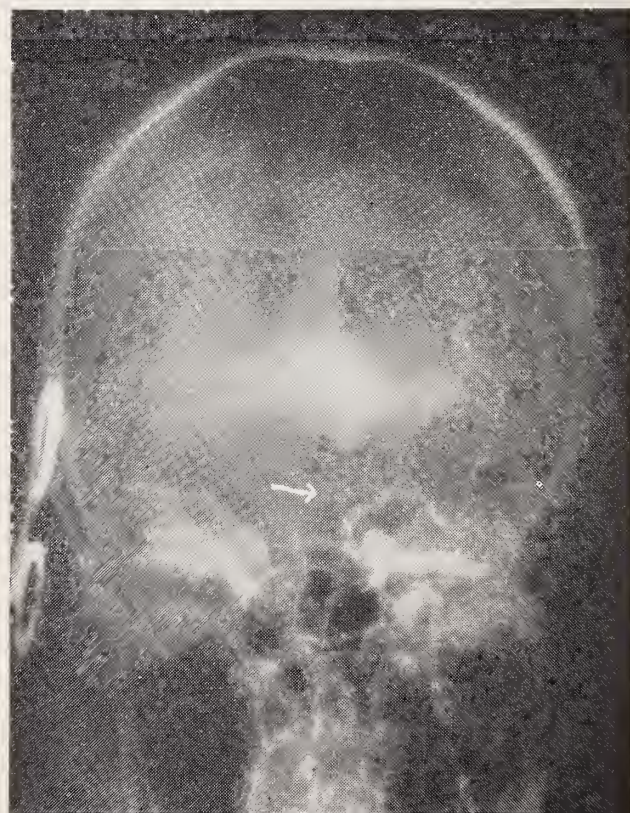
Fig. 9. Pedunculated aneurysm of the anterior cerebral artery. Arteriogram performed after initial rupture.

The Use of Cerebral Arteriography as a Multipurpose Diagnostic Aid



Artist's drawing of proper position for injection of 16 gauge needle.

Fig. 10. Thrombosis of the anterior cerebral artery. The artery is patent as far as the anterior communicating artery.



Roentgen Diagnosis of Gall Bladder Disease

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METICULOUS X-RAY examination of the gall-bladder is the most accurate procedure available for the diagnosis of disease of the extra hepatic biliary tract. This fact is of considerable importance to the medical profession and to their patients since the incidence of gall-bladder disease is rather high.

Data compiled by Lieber from a series of approximately 30,000 post mortems performed at several Philadelphia hospitals showed the following incidence of gall-stones in white patients: In the group 20 years of age and older there was an incidence of 21.7 per cent in women and 9.7 per cent in men or an overall incidence of 11.6 per cent. In the group 50 years of age and over the percentage rose to 27.8 per cent in women and 12.4 per cent in men. In diabetics the general incidence was 30.2 per cent. In diabetic women over 50 it was 50 per cent and in men over 50 it was 20 per cent.

The above statistics are for gall-stone occurrence only and do not take into account non calculous cholecystitis which, according to some authors, is seen in about eight out of every 100 cases of gall-bladder disease.

Since the definite diagnosis of this condition is, in most cases, a radiological problem it is well to look rather closely at the x-ray routine presently used, its practicality and diagnostic accuracy. I should, therefore, like to present briefly the routine procedure which we have used, for the past four years, at the John D. Archbold Memorial Hospital at Thomasville. No claim of originality is made for any part of this procedure.

The examination may be divided into two parts, the first being the plain or scout film and the second part being the cholecystogram.

The plain film which requires no preparation of the patient other than a cleansing enema may show one or more of the following diagnostic findings:

- (a) Typical gall-stone shadows
- (b) Calcification of the gall-bladder wall
- (c) Milk of calcium bile in the gall-bladder
- (d) Emphysematous cholecystitis produced by an infection of the gall-bladder with gas producing organisms
- (e) Gas in the biliary tract due to reflux from the duodenum secondary to either an incompetent sphincter of Oddi or to a fistulous opening between some part of the biliary and gastro-intestinal tract.

The plain film is especially indicated in all jaundiced patients and in those with acute and subacute cholecystitis.

If a definite diagnosis of gall-bladder disease cannot be made from the plain film and if there is no contraindication such as jaundice or severe hepatic or renal disease the second phase of the examination, cholecystography, is carried out. Six tablets of Telepaque are given at 6:00 P.M. following a meal that is low in fat but unrestricted in quantity. No food is allowed following the meal, however water, black coffee, or tea without cream is permitted. On the following morning the patient is given a plain water enema and one hour later is examined in the x-ray department.

Three films are made of the gall-bladder area with the patient lying in the lateral decubitus with the right side downward. A compression band is used for immobilization of the patient and a bucky diaphragm and small cone are used for all exposures. Two films are made with a moderately high voltage technique using factors as follows: 42 inch target film distance, 200 milliamperes and three twentieths of a second exposure. The kilovoltage is calculated by measuring the thickness of the patient in centimeters, doubling this measurement and adding forty-three. The third film is made with kilovoltage decreased by twenty and

X-Ray Examination for Diagnosis of Disease of the Extra Hepatic Biliary Tract



Fig. 1. Right-prone projection. Left-right lateral decubitus showing stratification of stones.

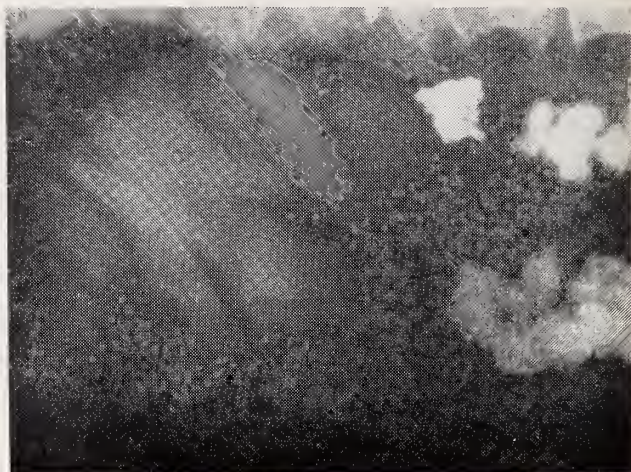


Fig. 2. Stratification of floating stones seen in right lateral decubitus film.

the exposure time increased to three tenths of a second.

These films are processed and viewed immediately. Further procedures are then carried out as indicated and may be catalogued as follows:

- (1) If the films are satisfactory and the gall-bladder is visualized the patient is given a six ounce glass of milk to which has been added an ounce of cream and the beaten up yolk of one egg. Ten to fifteen minutes later two films are made, one in inhalation and the other in exhalation, with the patient supine and with the left side elevated 8 Cm. These films are also processed and viewed immediately with especial reference to visualization of the biliary ducts. A final film is made one and one-half hours later with the patient in the prone position.
- (2) If the gall-bladder is not visualized or is of low density the patient is questioned as to whether he took the tablets, vomited after taking them, had diarrhoea of severe grade or failed to omit breakfast. If this questioning discloses no pertinent information then films are made in the prone and supine positions. If then no gall-bladder shadow is seen or if the gall-bladder is still poorly visualized the examination is repeated on the following day or as soon thereafter as is feasible.

This concludes a description of our routine cholecystographic examination. I should now like to discuss some of the steps in this procedure which we feel are distinctly advantageous.

Telepaque is used in preference to Priodax® or Monophen® since it has the highest iodine content of these three widely used cholecystopaques and therefore gives the most dense shadow in any gall-bladder that is able to receive and concentrate

bile. Since cholecystographic visualization of the gall-bladder is based primarily on the density of the concentrated medium in the gall-bladder, it is logical to assume that a lower degree of concentration will produce a visible gall-bladder shadow with Telepaque than with other media in present use. Visualization of poorly functioning gall-bladders should be increased by its routine use and the number of non-visualized gall-bladders should be decreased.

The increased density attained with the use of Telepaque might possibly obscure the presence of small stones, opaque or non-opaque, in the gall-bladder. The density can be controlled by the amount of the medium given. We have obtained gall-bladder shadows by giving two to four tablets of Telepaque that were comparable in density with the shadows normally produced by six tablets of Priodax. It is our conviction, however, that the method of choice is to administer six tablets routinely to all patients, obtain a dense gall-bladder shadow in those cases that have good function and compensate for the increased density by using a voltage higher than the conventional in the exposure of some of our films. This produces sufficient penetration of the gall-bladder shadow to facilitate a diagnosis of opaque calculi, non-opaque calculi or intraluminal tumor with as high a degree of accuracy as any other media provides. The use of a higher voltage has an additional advantage in that the time of exposure can be decreased. This is a definite factor in pre-

venting the loss of detail in a film produced by movement of the patient.

A single film taken at conventional voltage is useful in cases in which the gall-bladder functions poorly and greater contrast is necessary for its visualization.

The use of the lateral decubitus position with the right side down has several definite advantages. In this position the gall-bladder falls away from the gas containing intestine eliminating confusing shadows from this source in the vast majority of patients.

Another advantage is the stratification of calculi in the gall-bladder. In the majority of cases stones will gravitate to the most dependent portion of the gall-bladder and are visualized with such clarity that the diagnosis can be made without equivocation even though they are of minute size. A small percentage of calculi which are of lesser specific gravity than the bile in which they are immersed will float into a definite stratum at a level higher than the most dependent portion and will be visualized as a single or double line of decreased density transversely or diagonally across the gall-bladder shadow. While stratification of calculi can be obtained in the films made with the patient upright it has been our experience that obscuration from gas occurs in a large percentage of films made in this position.

Films made 10-15 minutes after the fatty meal as described above in many cases give good visualization of the cystic and common ducts and at times some opaque bile may be seen to empty into the duodenum. This is possible because of the greater iodine content of the gall-bladder bile obtained with Telepaque and also because of the apparent rather vigorous initial emptying response to the fat meal after using this medium. This is an interesting phenomenon and may prove to be of considerable worth in evaluating dyskinesia of the gall-bladder or spasm of the sphincter of Oddi.

Visualization of ducts of course depends on excellent concentration in the gall-bladder and it is possible that this degree of concentration may not occur in cases in which there is pathology of major nature in the bile ducts. So far all ducts we have visualized appeared to be normal. Experience, however, with this phase of the examination may change our concepts of the normal. Emptying response of gall-bladder rules out pres-

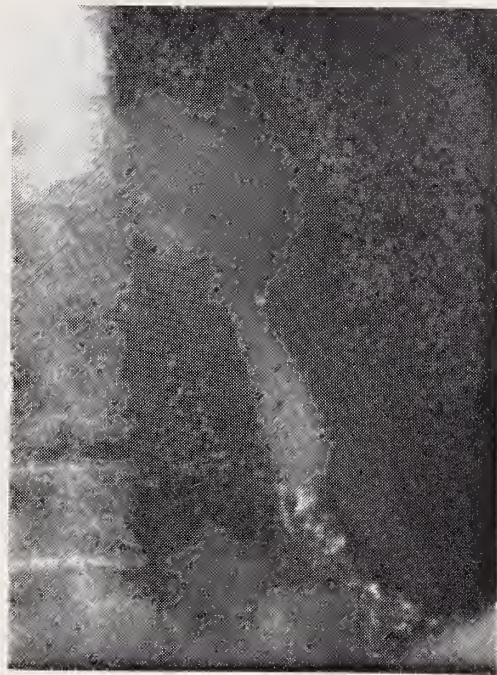


Fig. 3. Common duct visualized following fat meal.

ence of milk of calcium bile in cases where a scout film has not been made previous to cholecystography.

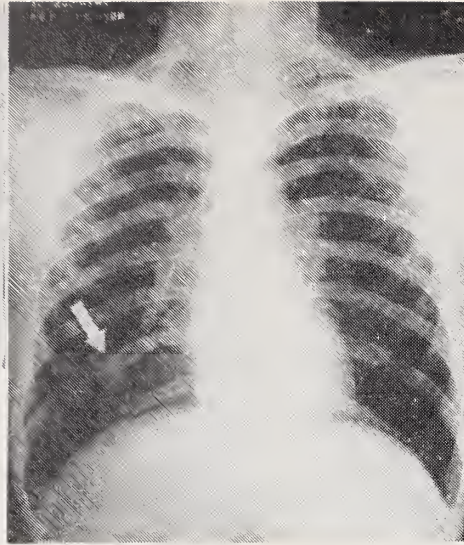
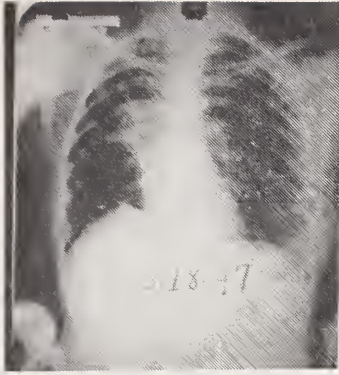
Summary

1. The plain or scout film may be diagnostic or provide significant information.
2. Telepaque is used for cholecystograms because its high iodine content results in dense gall-bladder shadows. This makes possible the visualization of the bile ducts as well as the gall-bladder in many cases.
3. The routine use of the lateral decubitus position for some of the films in cholecystography is recommended as a definite aid in diagnosis.
4. Repeat examinations are mandatory in non-functioning or poorly functioning gall-bladders. Every effort should be made in all such cases to rule out causes other than biliary tract disease that may be responsible for such dysfunction.

John D. Archbold Memorial Hospital

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Lung

Metastases

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THE DETECTION OF PULMONARY metastases in patients having primary malignant tumors elsewhere is very important in planning treatment, in establishing prognosis and in guiding discussion of the problem of cancer with the patient and relatives. No radical surgery or extensive radiation therapy should be planned without a preliminary film of the chest. Periodic chest radiographs should be an essential part of the follow-up of all cancer patients except those with small skin tumors. Melanoma is an exception.

Many cases of metastatic cancer of the lung can be detected on routine chest X-rays or mass surveys.

Incidence of Pulmonary Metastases

When all malignant growths are considered, metastases to the lung occur in about 30 per cent of all cases. The highest percentage occurs in carcinoma of the kidney with 75 per cent metastases, the next highest with carcinoma of the mouth and pharynx 20 per cent, carcinoma of the stomach 20 per cent and carcinoma of the liver and pancreas 20 per cent. Melanoma shows a 65 per cent incidence of metastases to the lung.

Warren⁶ found that cervical carcinoma exhibited pulmonary metastases in 15 per cent of his cases. Fifty-eight per cent of the carcinoma of the breast cases metastasized to the lung. The order of frequency of metastases as determined by Warren was as follows: (1) distant lymph nodes (2) lung (3) liver (4) bones (5) regional lymph nodes (6) skin (7) pleura (8) adrenal glands. In a series of cases reported by Marshall and Haire,⁷ 8.4 per cent of breast carcinomas showed metastases to the lung with 9.7 per cent to bone and 10.5 per cent in both the bone and lymph nodes.

Route of Spread

Metastases to the lung may occur by several routes: (1) through the chest wall directly to the pleura, (2) by the lymphatics and mediastinal nodes and into the lung tissue proper, and (3) by vascular channels.

Figure 1, Case I. Above, left. Radiation fibrosis. Note retraction of heart and mediastinum to right and elevation of diaphragm. No change in ten years.

Figure 2, Case II. Above, center. Annular lesion right lower lobe. Lobectomy. Tuberculoma.

Figure 2A, Case II. Above right. Close up of annular lesion right lower lobe.

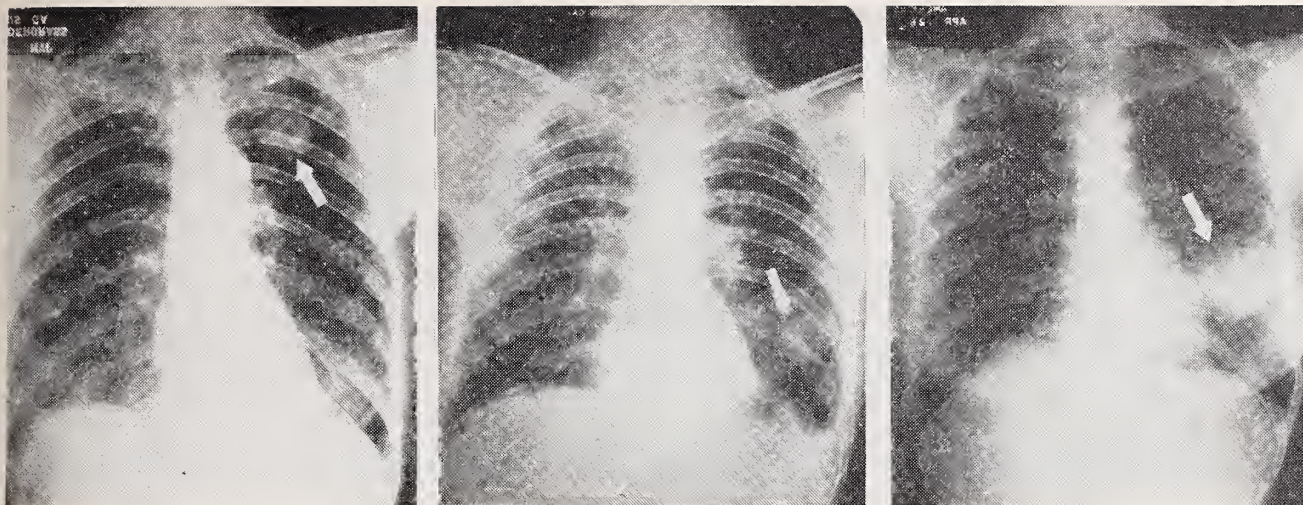


Figure 4, Case IV. Center. Annular lesion left lower lobe. Metastasis from hypernephroma.

Figure 3, Case III. Left. Annular lesion left upper lobe. Metastasis from melanoma.

Figure 5, Case V. Right. Annular lesion left lower lobe. Torula infection of lung.

Survey of Incidence, Route of Spread, and Diagnosis of Pulmonary Metastases

Differential Diagnosis

Metastatic lung cancer may simulate other diseases and assume many different forms. These may be roughly classified under the following headings: (1) pleural thickening or effusion, (2) linear infiltrations, (3) solitary or multiple annular shadows, (4) miliary seedings, (5) apparent cystic lesions, (6) bronchial stenosis with atelectasis or emphysema and (7) mediastinal and peribronchial adenopathy. It is obvious that the many radiological aspects which this disease may assume might be very confusing. Therefore, a complete history, a complete physical examination, clinical laboratory studies and a reasonable amount of diagnostic logic will be necessary to confirm the diagnosis of metastases to the lung.

Among the more confusing lesions are tuberculosis, radiation fibrosis, and Boeck's sarcoid. It is well to remember that a patient may have primary malignancy elsewhere and have pulmonary tuberculosis as well. Diligent examination of the sputum, with cultures and animal inoculation, may serve to differentiate the two diseases. While bacteriological studies are being carried out, the sputum should also be examined for tumor cells, utilizing a twenty-four hour specimen collected in 10 per cent formalin.

Boeck's sarcoid may produce diffuse lung lesions or enlarged hilar nodes. Biopsy of a peripheral lymph node may effect a solution.

Fibrosis occurring after radiation for breast carcinoma may easily be confused with metastatic disease. Here serial films over a prolonged period may be necessary before the two lesions can be differentiated. Radiation fibrosis may produce thickened pleura, linear fibrotic strands, atelectasis, shift of the mediastinum, and elevation of the diaphragm. We have followed some cases for periods of ten to fourteen years with little radiologic change. Radiation fibrosis is illustrated in Case I, Figure 1.

Fungus infections of the lung may produce multiple miliary shadows which are easily confused with metastatic cancer.

Careful examination of pleural fluid may reveal tumor cells, thus establishing the nature of the effusion.

Laminagraphic studies of the chest may demonstrate small metastatic lesions not detected on routine films. They are of particular value where one considers resection of a single metastatic nodule.

If the routine X-ray and laboratory studies do



Figure 7, Case VII. Center. Lymphangitic metastases right lung and pericardial effusion metastatic from carcinoma of the breast.

Figure 6, Case VI. Left. Atelectatic lesions left upper lobe and right middle lobe metastatic from carcinoma of the cervix.

not confirm metastatic disease, cytological study of bronchial washings may prove helpful.

Solitary Annular Lesions

Solitary annular shadows in the chest film present many diagnostic problems. When they occur in the presence of a known malignancy elsewhere, one is tempted to conclude that this represents a metastasis. On the other hand, when annular shadows are discovered on a routine chest X-ray, it should not be assumed that they are metastatic without further investigation. In this connection, four films are shown (Case II, Figure 2; Case III, Figure 3; Case IV, Figure 4 and Case V, Figure 5) in which there are annular lesions, all four of different etiology. It would be wrong to label any of these as definite evidence of metastases without exploration. Indeed, when these annular shadows appear in the lung, thorough physical, laboratory and roentgenological examinations are necessary to rule out primary malignancy elsewhere. If such a primary malignancy cannot be proved, surgical exploration of the solitary lesion in the lung is indicated.

Lesions produced by stenosis of bronchial branches may prove confusing. In Case VI, Figure 6, two lesions in the lung, metastatic from carcinoma of the cervix, are demonstrated. These might well, from the radiographic picture, resemble bronchogenic carcinoma.

In study of the lung for metastatic carcinoma, the possibility of metastases to the pericardium should not be neglected. In Case VII, Figure 7, there are shown metastatic linear infiltrations in the right lung from carcinoma of the breast with pericardial effusion.

Hilar Adenopathy

The presence of enlarged hilar glands may not necessarily mean that this patient has metastases

Figure 8, Case VIII. Right. Enlarged hilar glands from Boeck's sarcoid. Positive biopsy from axillary gland.

from a primary lesion elsewhere. The incidence of hilar adenopathy from various diseases is difficult to assess from the literature. It must be remembered, moreover, that the lymphomas, tuberculosis (especially in the Negro race), and sarcoid may produce enlargement of the hilar glands suggestive of metastases from malignancy. Case VIII, Figure 8.

Melanoma

While routine survey of the chest is not considered useful in the average case of carcinoma of the skin, all patients with lesions having any possible appearance of melanoma should have a chest X-ray before surgery is attempted. This is illustrated by Case IX, Figure 9. This patient had a pigmented lesion on his back treated by radium 3 years previously. He was admitted to the hospital for excision of the lesion, but X-ray revealed multiple nodules in the lung and definite evidence of pericardial effusion. Aspiration of the pericardium revealed melanoma cells. Surgery was considered inadvisable and the patient died in one month.

Pulmonary Metastases from Cervical Carcinoma

While pulmonary metastases from cervical carcinoma are relatively rare compared with those from other tumors, their detection in the individual case is important. The routine use of periodic X-ray examinations of the chest in cases of carcinoma of the cervix is apparently uncommon. It is believed that more frequent chest examinations in patients with cervical carcinoma will yield a higher incidence of positive findings than is indicated in the literature. The uniformly higher rate in necropsy studies, as opposed to radiographic studies, should stimulate more frequent chest examinations. The necropsy reports of Brunschwig and Alexander;¹ Henriksen;² and Laffont³ et al



Fig. 9, Case IX. Annular metastases and pericardial effusion metastatic from melanoma of back.



Fig. 10, Case IX. Multiple annular metastatic lesions from cervical carcinoma.

indicate that distant metastases, including pulmonary metastases, are more common than is generally realized.

Seaman and Arneson⁵ reported six cases of solitary metastatic lesions from cervical carcinoma, five of which had operations and pathological studies. Their article gives an excellent summary of the subject.

We have observed eight instances of pulmonary metastases from carcinoma of the cervix in 300 consecutive cases. One case is illustrated in Case X, Figure 10. These diagnoses have been based on clinical and radiographic findings and not on autopsies. Routine chest examinations were done on only a few of these cases.

Personal communication with several observers yielded some interesting findings. Hufford⁷ reported four cases of pulmonary metastases from carcinoma of the cervix in a series of 833 cases. Lampe⁷ reported 16 cases in 646 consecutive cases. Caulk⁷ reported two in 800 cases; Henderson,⁷ three in 600 cases; Corscaden and Kligerman,⁷ seven in 614 cases (three were considered possibly of primary bronchogenic origin); Beeler and Little,⁷ two in 84 cases. Elkins⁷ reported an approximate incidence of one per cent. Reeves⁷ reported approximately five per cent over a two or three year period. Robbins⁷ observed three cases in one year. Pierce⁷ reported that 26 per cent of 50 autopsied cases of cervical carcinoma at McGill University showed pulmonary metastases. The Tumor Registry of Royal Victoria Hospital reported on 362 cases of carcinoma of the cervix. Twenty-one of these came to autopsy and two cases or 9.5 per cent had pulmonary metastases. The incidence in another series of cases

was 2.6 per cent. Several radiologists reported that they had not observed pulmonary metastases from cervical carcinoma.

The above resume is incomplete. It is hoped that further investigations in large clinics will result in more information concerning pulmonary metastases from cervical carcinoma.

Summary

1. The importance of the detection of metastatic lung lesions is emphasized.
2. The incidence, route of spread, and differential diagnosis of metastatic pulmonary lesions is discussed.
3. Attention is directed to the fact that pulmonary metastases from carcinoma of the cervix occur with more frequency than is generally recognized.
4. Various radiological patterns are illustrated.

712 Crawford St.

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Surgery in Vascula

ROBERT B. GOTTSCHALK, M.D., Savannah, Ga.

EMERGENCY VASCULAR conditions demand prompt, correct treatment to preserve life and limb. Many times preserving the limb is the prime obligation, but not the final obligation assumed by the surgeon caring for a vascular emergency condition. The clamping and tying of a large vessel may preserve the life of the patient, but the extremity may be so deprived of blood supply that it will either become necrotic or produce a vascular cripple. Therefore, every effort should be made to restore circulation. The following cases represent the problems encountered and the methods used in an attempt to preserve vital circulation.

The first case illustrates the anatomical fact that the muscles of the lower extremity are in groups surrounded by a strong fascia and that this fascia will allow for only limited expansion. Bleeding into such an enclosed compartment will eventually cease because of compression, but the extremity distal to the injury will be deprived of its blood supply.

Case No. 1—This young, white, male suffered a gunshot wound of the left lower leg, on November 18, 1949. When first seen, there were multiple wounds over the lower leg, with the calf and anterior tibial areas markedly swollen and tight. The foot was dark, pulseless and cold. An incision was made from just below the knee to the ankle on the antero-lateral surface. This was carried through the fascia, allowing the muscle to expand, and the anterior tibial artery to be ligated.

A similar incision was then made on the postero-medial surface. Spinal anesthesia was used to insure blocking of the sympathetic nerve fibers. When the foot cooled again, a paravertebral lumbar sympathetic block, using bromosalizol, was performed. The incisions were closed separately later. The wounds healed satisfactorily and the ensuing foot drop was protected by a brace for about six months. For the past two years he has had no trouble with the leg and does heavy manual labor.

The second case represents a complete severance of the axillary artery without an external wound. It also illustrates the results of too long a delay in definite treatment.

Case No. 2—The left shoulder of this 18-year-old motorcycle rider struck the bumper of a large truck as he started to pass the truck. When the patient was first seen, the left radial pulse could not be felt. The patient was in shock and there was slight discoloration of the hand, together with

considerable swelling over the pectoralis muscles. He was given the usual treatment for shock, and hyaluronidase was injected into the swelling over the pectoralis.

It was hoped that this would relieve some of the edema and thus help to decide whether the loss of the radial pulse was due to pressure on the axillary artery or to direct injury to the artery itself. As soon as it was evident that the artery was damaged, he was taken to the operating room; an incision was carried along the inferior border of the clavicle, and on to the shoulder and left upper arm. The pectoralis major and minor were divided and the great vessels uncovered. The axillary artery was completely divided and bleeding. The torn vein was ligated.

It was impossible to bring together the two ends of the artery for suturing and so to bridge this gap, a five-inch section of the greater saphenous vein was removed from the opposite leg. The continuity of the vessel was established by an end-to-end anastomosis. The vein at first dilated, then as blood flowed through it, it contracted down to equal the size of the artery. Aqueous heparin was injected directly into the lumen of the artery, both proximal and distal to the graft. It was possible to see the blood flowing down through the graft and within a short time, the color of the hand improved. Six hours had elapsed from the time of the injury until blood was flowing into the hand, and the muscles on the volar surface of the forearm began to contract, presenting the picture of claw-hand. There was considerable swelling of entire hand and arm for a period of two weeks. The radial pulse was palpable on the tenth day. At the end of the first month he had no voluntary motion in the upper arm, forearm or hand. In the seven months since the injury he has had gradual return of function in the upper arm and some in the forearm and has had some motion in the wrist and fingers. If the operation had been performed earlier, return of function would have been earlier and more complete.

The third case represents the result of a more prompt repair of the femoral artery, with promise of greater return of function.

Case No. 3—This 18-year-old, white airman was run over by a loaded gasoline trailer-truck. The wheels exerted the greatest weight over the left inguinal region and lower abdomen. Examination showed evidence of compression syndrome, with bleeding from the nose and subconjunctival hemorrhages. The abdomen was rigid and with a rapidly expanding mass over the left inguinal area.

Both legs were severely contused. The toes of the left foot had been crushed. The left leg and foot were pulseless and cold. X-rays showed a fracture of the superior ramus of the left pubic bone. The patient was in shock, despite the fact that he was receiving blood in each arm. Because of the rigid abdomen, abdominal exploration was carried out immediately. There was free blood in the peritoneal cavity and bleeding into the mesentery, but no injury to the bowel. Incision was made over the left inguinal region to expose the femoral vessels. The contused, lacerated vein was doubly ligated and this controlled most of the bleeding.

Examination of the artery revealed that a section about one and one-half inches in length was severely contused and

Emergencies

A Report of Treatment Employed in Five Illustrative Cases

no blood was flowing through it. A long section of the opposite superficial femoral vein was used to bridge the artery after the contused area had been removed. Aqueous heparin was injected into the lumen of the artery, proximal and distal to the graft, and he was given depot-heparin for four days. The color in the foot improved shortly after blood began flowing through the graft. Post-operatively, he developed marked edema of the entire leg, but this gradually subsided with elevation of the leg. Dry gangrene of the toes developed, but the remainder of the foot had a good blood supply and the posterior tibial pulsations were excellent.

His general condition remained precarious for several days, with hematuria and almost complete renal shut-down for the first 24 hours. He received nine pints of blood during operation and eight pints post-operatively. Transmetatarsal amputation of the toes was performed but he now has a serviceable foot. Paralysis of the Tibialis Anterior muscle persists. This may show some recovery.

In retrospect, I believe that fasciotomy from groin to ankle should have been performed in order to relax the pressure on the vessels in the closed compartments of the leg.

The case of an aneurysm of the innominate, right common carotid and subclavian arteries does not represent an emergency in the same sense as the previous cases. However, in the case to be discussed it is emergent because if it had been left alone, it probably would have ruptured within a short time.

Case No. 4—This 63-year-old, colored male began having hoarseness in 1949. Later, he developed a mass in the neck and partial paralysis of the right arm. He sought medical aid because of severe pain in his right shoulder and arm.

Examination revealed a large pulsating mass, extending from behind the clavicle up into the neck. The overlying skin showed some trophic changes. Carotid pulsations were present, but no radial pulsations could be felt. There was partial destruction of all nerves to the hand and considerable atrophy of the intrinsic muscles of the hand.

Fluoroscopic examination showed paralysis of the right diaphragm and a pulsating mass that filled the right upper chest. This mass appeared to be separated from the arch of the aorta. The surgical approach consisted of both a neck and a chest incision, entering the chest through the second intercostal space. The aneurysm had practically eroded the manubrium and first rib. The Sac was gradually separated from the manubrium, following which the manubrium was divided vertically. This, with lateral division of the clavicle, allowed the sternum, clavicle and first two ribs to be retracted laterally, and gave a good exposure. The innominate, carotid and subclavian arteries were clamped and divided allowing the aneurysm to be removed. All vessels were ligated and the wound closed in the usual manner.

A modified upper thoracic sympathectomy was performed to insure as much blood flow as possible to the brain and right arm. Post-operatively, he had immediate paralysis of the entire left side. The leg recovered within eight hours.

The arm has taken much longer, and now about eight

months later he has good motion in the upper arm, but finer movements of the hand have not returned completely. A vein graft between the internal carotid and innominate arteries would have helped to relieve the cerebral anemia. Despite the fact that there was considerable calcification in the innominate, this procedure will be considered more seriously if another opportunity presents itself.

Thrombosis and embolism of the great vessels, likewise, call for prompt surgery. Whenever possible the clot should be removed and heparin injected proximal to the clot in an attempt to prevent its reforming. The fifth case represents a case of thrombosis of a vessel with late removal of the clot and a failure to re-establish the circulation.

Case No. 5—This young colored male was awakened on January 7th, 1952 with cramping and pain in the left leg. The leg became cold and when first seen in the afternoon, the dorsalis pedis and posterior tibial pulsations were not felt. Several days before, he had had transurethral manipulation for a low lying ureteral calculus. Presumably, the popliteal area had been bruised by the stirrups sufficiently to cause inflammation within the artery. As soon as he was admitted to the hospital, a paravertebral lumbar block was carried out with no appreciable improvement. Later, the popliteal area was explored and a clot removed from the artery. Unfortunately it was impossible to force any fluids through the artery distal to the site of the clot. The leg had to be amputated below the knee subsequently. Much better results could have been expected if surgery had been performed several hours earlier.

In summary five cases have been presented which illustrate different types of surgical vascular emergencies encountered and methods of treatment employed.

Since this paper was written, one additional vein graft to the femoral artery was done. The artery was injured during the repair of a hernia. The vein graft was done through the hernial incision. Dorsalis pedis pulsation was present within 36 hours, and the foot maintained good color and temperature, post-operatively.

123 Jones St., East

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Case 4—Williams, Mark H., *Accidental Incision of Aneurysm of Left Common Carotid Artery; Treatment of Thoracocervical Excision with Recovery*. *American Surgeon*, 135, and 267 through 277. February 1952.

The Classification of Patients with Diseases of the Heart

FUNCTIONAL CAPACITY

- Class I** Patients with cardiac disease but **without resulting limitation of physical activity**. Ordinary physical activity does not cause undue fatigue, palpitation, dyspnea or anginal pain.
- Class II** Patients with cardiac disease resulting in **slight limitation of physical activity**. They are comfortable at rest. Ordinary physical activity results in fatigue, palpitation, dyspnea or anginal pain.
- Class III** Patients with cardiac disease resulting in **marked limitation of physical activity**. They are comfortable at rest. Less than ordinary activity causes fatigue, palpitation, dyspnea or anginal pain.
- Class IV** Patients with cardiac disease resulting in **inability to carry on any physical activity without discomfort**. Symptoms of cardiac insufficiency or of the anginal syndrome are present even at rest. If any physical activity is undertaken discomfort is increased.

THERAPEUTIC CLASSIFICATION

- Class A.** Patients with a cardiac disease whose physical activity need not be restricted.
- Class B.** Patients with cardiac disease whose ordinary physical activity need not be restricted, but who should be advised against severe or competitive physical efforts.
- Class C.** Patients with cardiac disease whose ordinary physical activity should be moderately restricted, and whose more strenuous efforts should be discontinued.
- Class D.** Patients with cardiac disease whose ordinary physical activity should be markedly restricted.
- Class E.** Patients with cardiac disease who should be at complete rest, confined to bed or chair.

NO HEART DISEASE: PREDISPOSING ETIOLOGICAL FACTOR*

These are patients in whom no cardiac disease is discovered, but whose course should be followed by periodic examinations because of the presence or history of an etiological factor that might cause heart disease. These cases should be recorded as *No Heart Disease: Predisposing Etiological Factor* and it is essential that the etiological diagnosis also be stated.

UNDIAGNOSED MANIFESTATION*

Patients with symptoms or signs referable to the heart but in whom a diagnosis of cardiac disease is uncertain should be classified tentatively as *Undiagnosed Manifestation*.

Reexamination after a suitable interval will usually help to establish a definite diagnosis. When there is a reasonable probability that the signs or symptoms are not of cardiac origin, the title *Undiagnosed Manifestation* should not be used. The diagnosis then should be *No Heart Disease*.

*There are patients in whom the symptoms or signs, though suggestive of cardiac disease, do not justify a definite diagnosis, and from whom is obtained a history of an etiological factor which might cause heart disease. The diagnosis in such cases should include both *No Heart Disease: Predisposing Etiological Factor* and *Undiagnosed Manifestation*.

From *Nomenclature and Criteria for Diagnosis of Diseases of the Heart and Blood Vessels*, Fifth Edition, 1953. (See this book for complete diagnostic criteria.)

Prepared by the Criteria Committee of the New York Heart Association
Distributed by American Heart Association, 44 E. 23rd Street, N. Y. 10, N. Y.
and its affiliates



Standard Nomenclature in Cardiac Diagnosis

JOB PLACEMENT in industry or the home, and modern medical treatment, frequently require the services of various members of a group. The general practitioner or specialist may initiate and guide the treatment but often other technicians or specialists are required to help in the conduct of the case and to provide certain specific therapeutic techniques.

For effective work in such a group it is essential that all members of the group speak the same language or that there be a clear definition of terms. In medicine it is important that there be no ambiguous terminology or uncertain reference. This is true in referral of patients to doctors or clinics, in reporting illnesses or in making claim for compensation or insurance benefits.

Heart cases particularly need to be clearly diagnosed and accurately evaluated in order to obtain the most effective treatment and the most efficient care. In a specific case a worker suffers a moderate degree of myocardial insufficiency which is apparent to the doctor who is treating him for an acute illness. This, the patient called "flu" but it was actually determined to be rheumatic fever. The convalescence was lengthened because there was found to be some pre-existing valvular damage. In reporting this to the plant physician, on the patient's return to work, the family doctor gave the diagnosis as acute rheumatic fever, convalescent, with mitral valve lesion (insufficiency and stenosis) rheumatic in origin, accompanied by auricular fibrillation. He gave a Functional Capacity of Class 2 and Therapeutic Class C. With this report the plant physician had all the information necessary to properly place the returning worker in a job where he would be safe and ef-

ficient in his work. This would not have been true had the case been reported as a heart attack, heart failure, etc.

Similarly, a child found to have a heart murmur on routine school examination was referred to his family doctor who diagnosed the condition as congenital cardiac defect, patent ductus arteriosus, Functional Capacity Class 1, Therapeutic Classification Class A. In spite of the good functional and therapeutic classification, the clear cut diagnosis of a defect curable by surgery led to the use of the most modern and effective type of treatment. Because the family was indigent the child was referred for surgery to the Crippled Children's Division through a Georgia Heart Association Cardiac Clinic.

The standard nomenclature for cardiac diagnosis sets up criteria for diagnosis and a system of accurate terminology for etiology, anatomical and physiological factors and symptomatology. Also there is a functional and therapeutic classification which completes the list. A plea is made for doctors generally to obtain a copy of this book and use it as a guide in recording their diagnosis and in the referral or treatment of patients.

The book is distributed by the American Heart Association, Inc., with the title "Nomenclature and Criteria for the Diagnosis of Diseases of the Heart and Blood Vessels." It may be obtained at cost (\$4.95) by writing to the Georgia Heart Association, 318 Western Union Building, Atlanta, Georgia. The functional and therapeutic classifications are published on the facing page. They may be obtained in wall chart form or on a convenient card without cost by writing to the Georgia Heart Association.

Notes on practical aspects of cardiovascular diseases . . .
a monthly contribution of the Georgia Heart Association.

abstracts by georgia authors



Alving, Alf S., Hankey, Daniel D., Coatney, G. Robert, Jones, Ralph, Jr., Coker, Walter G., Garrison, Paul L., and Donovan, William N. "Korean Vivax Malaria. II. Curative Treatment with Pamaquine and Primaquine." *Am. J. Trop. Med. and Hyg.* 2:970-976. (Nov.) 1953.

Experiments in this country showed that Primaquine had promise of being a curative anti-malarial agent. It is chemically related to Pamaquine (Plasmochin). Three hundred fifty-five patients with a relapse of Korean vivax malaria were treated with Chloroquine alone and 39 per cent relapsed. Two hundred seventy-two patients were treated with Pamaquine and Chloroquine and 0.7 per cent relapsed. Three hundred forty-eight patients were treated with Primaquine and Chloroquine and none relapsed. The Primaquine dosage was 15 mg daily for fourteen consecutive days. Because of the previously proven lower toxicity of Primaquine, it was suggested that the combination of Chloroquine and Primaquine constitute the treatment of choice for the radical cure of Korean vivax malaria.

Boling, Edgar, Emory. "Comparative Studies of Fecal Bacterial Flora After Antibiotics," *Sou. Med. J.* 47:113-137 (Feb.) 1954.

Oral Chloromycetin with dihydrostreptomycin in combination, or sulfonamide did not decrease total bacterial count of intestinal flora. Marked depression of coliform group and pathogenic streptococci were noted by both agents. Marked overgrowth of yeast after these drugs did not produce the usual pathologic effects, namely, diarrhea, pruritus ani, and tenesmus that frequently follow the administration of Aureomycin. These studies were made at the Georgia Baptist Hospital, and the methods used duplicated the work of Dr. Ralph Allen of Miami, using Terramycin. There is need for critical clinical research in this field for comparative evaluation of efficacy and untoward side effects of antibiotics in use today.

Coatney, G. Robert, Alving, Alf S., Jones, Ralph, Jr., Hankey, Daniel D., Robinson, Donald H., Garrison, Paul L., Coker, Walter G., Donovan, William N., Di Lorenzo, Anthony, Marx, Ralph L., and Simmons, Ingalls H. "Korean Vivax Malaria. V. Cure of the Infection by Primaquine Administered during Long-term Latency." *Am. J. Trop. Med. and Hyg.* 6:985-988 (Nov.) 1953.

As shown in the above papers, Chloroquine plus Primaquine produces a radical cure of Korean vivax malaria. Since this disease has exhibited a long latent period, it was wondered if Primaquine given during the latent period would prevent the late relapses. During the Spring of 1952, two hundred ninety-four men who had recently returned from Korea but who had not shown signs of malaria were given Primaquine 15 mg per day for fourteen days. During the follow-up period of six months, none of these men developed malaria. At the same time, three hundred thirty-one men were given Placebo tablets. These men were identical to the first group in that they had recently returned from Korea and had not previously had malaria. Fifty-eight of these men (17.5 per cent) developed Korean vivax malaria within six months after receiving the placebo. This rate approximates the expected attack rate of malaria among returning Korean veterans. This demonstrates the effectiveness of curing vivax malaria of Korean origin by giving Primaquine during the latent period.

Foraker, Alvan G., Aguilar Celi, Polinestor, and Denham, Sam Wesley. "Dehydrogenase activity in normal and hyperplastic endometrium." *Cancer* 7:100-105, (Jan.) 1954.

The localization of sites of dehydrogenase activity within human endometrium was studied histochemically. These enzymes have been found in other studies to correlate with sites of cell growth and rapid cell metabolism. The results showed: 1. Marked dehydrogenase activity in the glandular epithelium during the menstrual cycle and in hyperplasia. 2. Materially less evidence of such enzyme activity in atrophic endometrium. 3. Enzyme activity in endometrial stroma during the premenstrual phase. Sites of dehydrogenase activity in human endometrium corresponded to regions of growth and change in the cellular pattern of endometrium.

Foraker, Alvan G., Denham, Sam W., and Johnston, M. Harlan. "Histochemical Changes in Irradiated Ovaries. II. Carbohydrate and Lipid Localization." *A.M.A. Arch. Path.* 57:30-35, 1954.

The left ovaries of 12 rabbits were subjected to 200 kvp irradiation for a single dose of 400 r. Four weeks later six of the rabbits were used in negative and six in positive Friedman tests. Tissues from all ovaries were stained to demonstrate glycogen and other carbohydrates and to demonstrate lipid. The results showed little evidence of irradiation damage of the stromal cells either in pattern or in lipid content; obliteration of many of the ova in irradiated ovaries, those remaining being largely atretic with no stainable lipid and with a considerable deposition of a carbohydrate substance, not glycogen; and little evidence of ability of the irradiated ovaries to respond to the hormonal stimulation of the Friedman test.

(From the Departments of Pathology, Obstetrics and Gynecology, and Radiology, Emory University School of Medicine, and Grady Memorial Hospital, Atlanta, Georgia).

Hankey, Daniel D., Jones, Ralph, Jr., Coatney, G. Robert, Alving, Alf S., Coker, Walter G., Garrison, Paul L., and Donovan, William N. "Korean Vivax Malaria. I. Natural History and Response to Chloroquine." *Am. J. Trop. Med. and Hyg.* 2:958-969 (Nov.) 1953.

As a result of the Korean conflict, large numbers of our military personnel contracted vivax malaria while in that country. Studies of these men revealed that Korean malaria was of the temperate zone type of vivax malaria and had a latent period of six to fourteen months. This explains why the men who returned to the United States late in 1950 did not begin having relapses until the Spring of 1951. Chloroquine suppression taken once weekly adequately suppressed the primary attack in the vast majority of men even though infection occurred. The duration of illness from time of exposure to the last relapse was less than twenty-one months. The low instance of Korean vivax malaria in Negroes (5 per cent) suggested that the American Negro has considerable racial immunity to this disease. The acute symptoms of relapsing Korean vivax malaria were readily controlled with Chloroquine. Relapses after treatment with Chloroquine were common and usually occurred within four months.

Harrison, J. Harold, Atlanta, Dept. of Surg., Emory University School of Medicine, Atlanta. "Dextran as a Plasma Substitute with Plasma Volume and Excretion Studies on Control Patients." *Ann. Surg.* 139:137-142 (Feb.) 1954.

Thirty ward patients with no suspected alteration in blood volume were given 1000 cc. of 6 per cent dextran in 0.9 per cent saline solution. Following the infusion they were found to have a plasma volume increase (as determined by Evans Blue Dye) of 823 cc. and a blood volume increase of 909 cc. An average of 30.6 per cent of the dextran was excreted in 24 hours, 20.5 per cent of this being excreted in the first six hours. Of some 500 patients given dextran in shock therapy, there were reactions in only three, the most severe one reported here which responded well to supportive care.

Dextran more nearly meets all the criteria for a synthetic plasma volume expander than any other substance available at the present time. It can be safely stored and be readily available when needed. The low percentage of reactions encountered with its use as compared to plasma and blood make it safer to give, particularly to patients in shock in whom reactions are more severe, or to patients under anesthesia in whom reactions are harder to detect. The present evidence suggests that dextran may practically replace plasma and greatly supplement blood as a volume expander.

Mickle, W. A. and Ades, H.W., Emory University School of Medicine, Atlanta. "Rostral Projection Pathway of the Vestibular System." *Am. J. Phys.* 176:243-246 (Feb.) 1954.

Search for a possible area of representation of the vestibular system in the cerebral cortex has been the subject of much investigation. In the present study, which was carried out in cats, direct electrical stimulation of the vestibular branch of the VIII cranial nerve evoked potentials in a rostrally



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directed group of fibers which had connections with a localized field of the cerebral cortex. It was found that the impulses were carried by a fiber tract which had origin in the vestibular nuclei, crossed immediately to the opposite side and came to lie between the medial and lateral lemnisci, where it was closely associated anatomically with both auditory and somatic fibers. The thalamic relay point lay on the anterior and medial border of the medial geniculate body. From this point, third order neurons projected to the anterior supra sylvian gyrus, just rostral to the primary auditory area. The fibers from the labyrinths appeared to cross completely with no ipsilateral fibers above the vestibular nuclei. The fiber tract was small and its diffusion among the auditory and somatic fibers made its identification by histological method difficult.

Mohr, Carol O., Good, Newell E. and Schubert, Joseph T. Communicable Disease Center, Atlanta. Status of Murine Typhus Infection in Domestic Rats in the U.S., 1952, and Relation to Infestation by Oriental Rat Fleas. Am. J. of Pub. Hlth. 43:1514-1522 (Dec.) 1953.

Murine typhus fever in the United States is widespread among domestic rats on farms and isolated rural premises in the area where the average January temperature is 47° F. or higher and the humidity high. It was also originally common in this area in villages, towns and cities but, because of cooperative state-federal typhus control programs, it has been eliminated from many. It is spottily distributed on farms in and near the 40°-45° F. area and unknown north of it, although any typhus eradication program would have to be based on the thesis that any large farm, stockyard, mill, or similar premises with long-standing rat and rat ectoparasite infestation, *might harbor* typhus infection particularly if close to the 40° F. area.

Typhus occurs considerably farther north in villages, towns, and cities than on farms and in individual rural premises due to artificial heating in the town and city buildings. However, it is relatively easy to eradicate in such areas because it is present in a low percentage of premises and more subject to organized control. The farther into the cooler and more arid climates the smaller the foci, the more widely scattered, the less stable, and the more easily controlled.

In Georgia, in 1945, '46 and '47, before effects of the state-federal typhus control campaign were fully felt, 32 per cent of the 506 rat-infested farm premises surveyed in 13 counties in the 45 to 50° area yielded rats with typhus antibodies. Forty seven of 2,042 such premises in 19 counties in the 50-55° area were positive. In 1951 and 1952, only 2 per cent of 51 premises in the former area and only 11 per cent of 476 in the latter area were positive in counties where rural DDT dusting program had been carried on one or more years.

Norris, J. C., Emory University School of Medicine, Atlanta. "Krukenberg Tumors," Sou. Med. J. 47:116-120 (Feb.) 1954.

The published report deals with the clinical and pathologic features of Krukenberg Tumor as originally described by Krukenberg in 1896, and two patients are presented, one a female age 30 whose condition was quite typical from all other types; and another patient, a male age 65, whose primary tumor was at the ileocecal junction where it had produced obstruction, and whose cellular characteristics were quite similar to those found in lesions other than the ovary. A brief summary of other reports of Krukenberg tumors is

also made. A discussion is also included about the mystery of the tumor cells from the primary lesions invading other structures, especially the ovaries. There is no answer, but a theory is advanced. A portrait of Doctor Krukenberg, the first published in America is contained in the report, with a brief historic record about him. In the final summary the symptoms of Krukenberg tumor are given, and the conclusion is arrived at that the only treatment is surgical removal of the tumor; however, the ultimate result is serious, and discouraging.

Steadman, Henry E. and Jernigan, H. W., Atlanta. "Parathyroid Adenoma with Fibrocystic Skeletal Changes Resulting in Pathologic Fracture of the Femur." J. Int. Coll. Surgs. 21:30-47 (Jan.) 1954.

"The review of the literature concerning the history, embryologic background, the characteristics and function of parathyroid adenoma is presented. A case history is reported of pathological fracture of the hip in which X-ray and biopsy of the bone at the site of fracture was very suggestive of sarcoma of the bone.

A small and deeply situated parathyroid adenoma was removed from the neck with complete recovery of the patient and rapid healing of the fracture."

Witham, A. Calhoun and Hamilton, Wm. F., Depts. of Med. and Phys., Medical College of Georgia, Augusta. "Mechanical Inscription of the Vector-Cardiogram." Circulation 9:276-280 (Feb.) 1954.

A modification of the vectorcardiographic method of studying electrical events is presented. Simultaneous scalar leads, taken by any vector lead system, are first recorded. The important time intervals, difficult or impossible to read from the loop itself, are measured from these tracings. Proper pairs of the scalar leads can then be rapidly integrated into vector loops by an easily constructed drawing board based on the pulley system. This instrument is described in detail. It is demonstrated that loops so derived do not appear to differ in their important characteristics from electronically integrated ones.

Wright, E. S., Emory University School of Medicine, Atlanta. "Contact Ulcer of the Larynx." Sou. Med. J. 47:148-154 (Feb.) 1954.

A benign, non specific inflammatory lesion, involving primarily the vocal processes of the arytenoid cartilages. Most often observed in men in the fourth and fifth decades and due to vocal abuse, stress, tension and altered phonatory expression. Symptoms are neither specific or characteristic. Most frequent are a sensation of hypo pharyngeal and laryngeal discomfort, tiredness and aching after excessive use of voice, frequent break in voice while speaking, pain, blood tinged sputum and variable hoarseness. The lesion appears on laryngeal examination as a unilateral or bilateral ulceration or protruding granulomatous formation. Diagnosis determined by mirror laryngoscopy, direct laryngoscopy and biopsy. Laryngeal tuberculosis and malignancy are the principal diseases from which contact ulcer must be differentiated.

Treatment consists primarily of complete vocal rest, vocal moderation, excision of granuloma, depending on duration and size of granuloma and vocal reeducation. Response to treatment is quite variable, from several months to two to three years. Prognosis is generally good with perseverance and continued cooperation of the patient. Case reports.

Treutlen County Hospital Soperton, Georgia

The Treutlen County Hospital of twenty-five beds at Soperton, Georgia was opened for the reception of patients in February, 1954. This hospital will serve the citizens of Treutlen County and adjacent areas. This is the first hospital in Treutlen County.



doctor placement page

AVAILABLE PHYSICIANS

Bachelor, Mary n. R., M.D., General Hospital, Knoxville, Tenn., age 33, priority 4, married, Methodist, desires general practice in community of 5,000 to 25,000 with well equipped hospital, in Georgia. Graduated University of Tennessee, 1950. Will consider group and industrial practice. Available March, 1954.

Bates, Phillips L., M.D., Quarters "L," U.S. Naval Hospital, Camp LeJeune, N. C., age 35, resigning to inactive reserves, married, Presbyterian, specialty—Urology, desires clinic or as an assistant or associate in community of 30,000 in Georgia, graduate University of Rochester, 1946.

Dwight, J. Brown, M.D., Capt. USAF (MC) 3320th Medical Group, Amarillo AFB, Texas, age 28, at present a physician in the Armed Forces to be released from active duty in January, married, Protestant, graduate Bowman Gray School of Medicine, 1946, completed residency in OB-GYN at the University of Virginia, specialty—Obstetrics and Gynecology.

Dodd, Patricia, M.D. (See Dr. Robert S. McDuffie), age 33, married, desires surgery in community as individual, group or an associate, graduate University of Maryland Medical School, 1944, available April 1, 1954.

Douglas, John J., M.D., 726 14th Ave., Monroe, Wisc., age 38, married, Protestant, desires radiology or an association with doctor in Georgia, graduate University of Rochester School of Medicine.

Gianoulis, James T., M.D., 611 West Grace Street, Richmond 20, Va., age 38, priority 4, married, desires general surgery and gynecology with established surgeon, group or hospital in Georgia, graduate Medical College of Virginia, 1941, six years surgical residency at Medical College of Virginia Hospitals, now available.

Hall, Irving E., Jr., M.D., 8301 16th Street, Silver Springs, Md., age 29, married, Protestant, graduate Cornell University Medical College, 1950, residency at Children's Hospital of D. C., pediatrics, priority 4, interested in pediatrics in Georgia, prefers community of 10,000 to 50,000, available July, 1954.

Hallstrand, David E., M.D., 5 Geisinger Court, Danville, Pa., age 34, priority 4, married, Methodist, desires general surgery in clinic or as an assistant or associate, in Georgia. Graduate Emory University School of Medicine, 1945, graduate University of Pennsylvania School of Medicine, 1950, in surgery, residency at Geisinger Memorial Hospital and Foss Clinic, available July 1, 1954.

Hendrix, Paul C., M.D., 160 South Church Street, Wytheville, Va., served two years in Army with overseas duty, graduate Emory University School of Medicine, 1947, licensed to practice in Georgia, completed 12 months internship and 15 months medical residency at City Hospital, Winston-Salem, N. C., desires general practice in Georgia. Available now.

Hunter, I. H., 204 East Hill Avenue, Valdosta, Ga., age 72, married, Missionary Baptist, graduate Grant University, Tennessee, 1903, specialty pediatrics, prefers community of 1,000, will accept good position with clinic, available April 1, 1954, been in active practice for 50 years.

Ireland, Charles Robert, M.D., Medical College of Georgia, Augusta, Ga., age 34, married, one child, Catholic, graduate Medical College of Georgia, 1950, specialty—internal medicine, interested in cardiology.

Johnston, J. Howard, M.D., 107 Dauntless Lane, Hartford, Conn., age 36, married, two children, graduate Dartmouth College, 1939, A.B. degree, Long Island College of Medicine, 1943, M.D. degree.

Kaley, J. S., M.D., 887 Myrtle Street, N. E., Atlanta, Ga., age 33, graduate Vanderbilt University, 1946, interested in general surgery in Georgia.

Leigh, Cortland D., M.D., Route No. 1, Box 337, Odessa, Fla., age 38, married, Presbyterian, graduate University of Pittsburgh School of Medicine, 1940, residency in general surgery at St. Luke's Hospital, New York City, and in thoracic surgery at Seton Hospital, in private surgical practice from 1951 to 1953, desires community in need of surgeon or an associate, now available.

Lippett, Devereux, M.D., 125 Elfrehth Alley, Philadelphia, Pa., age 29, married, Episcopal, graduate Harvard Medical School, 1947, desires community in Georgia in clinic or as an assistant or associate in pathology and clinical pathology, available July, 1954.

Lipscomb, James W., M.D., 221-C Georgia Tech-Lawson Apartments, Chamblee, Ga., graduate University of Virginia School of Medicine, 1952, residency in internal medicine at the VA Hospital in Atlanta, will be completed by July 1, 1954, desires internal medicine, will consider general practice in community in Georgia, willing to start new practice or to associate in practice already established.

Lyles, William Sloan, M.D., 12 B College Village, Winston-Salem, N. C., age 30, married, Episcopal, graduate Medical College of South Carolina, 1947, 4½ years general surgery, specialty—general surgery, board qualified, prefers private practice, desires community of 5,000 to 60,000, available July 1, 1954.

May, Robert M., M.D., 1908 Rosemary Hills Drive, Apartment 1, Silver Springs, Md., born Hamburg, Germany, citizen U. S., married, Hebrew, graduate Louisiana State School of Medicine, 1948, residency at Touro Infirmary, Louisiana, priority 4, specialty Ob-Gyn only, desires community in Georgia, available anytime.

McDuffie, Robert S., M.D., U.S. Naval Hospital, Quarters No. 1219, Quantico, Va., age 34, married, in Navy as reserve medical officer, graduate Emory University School of Medicine, 1944, desires location where he and wife can practice as individual, group or associate, limited to Ob-Gyn, available April 1, 1954. (See Dr. Patricia Dodd).

Merchant, John P., Jr., M.D., P. O. Box 1017, South Miami, Fla., age 28, single, Baptist, graduate Medical College of Alabama, 1952, interested in general practice, prefers community in Georgia, available July 1, 1954.

Mitchell, Helen Krysa, M.D., 25 East Washington Street, Chicago 2, Ill., age 37, married, Catholic, graduate University of Illinois, 1943, residency in dermatology at University of Chicago, specialty—dermatology or public health, desires community of 50,000 in Georgia, available three to six months notice.

Morrow, John G., Jr., M.D., Dept. of Anesthesiology, Presbyterian Hospital, Charlotte, N. C., age 29, married, Methodist, now on active duty, graduate University of Maryland School of Medicine, 1947, residency, Lahey Clinic, Massachusetts, USN Hospital, Maryland, specialty—anesthesiology, desires community in Georgia, available March 15, 1954.

Mozola, Emil W., M.D., 2624 Noble Road, Cleveland Heights 21, Ohio, age 38, married, Catholic, graduate Hahnemann Medical College and Hospital, 1943, priority 4, would like progressive community in Georgia, had considerable experience in orthopedic, urological, gynecological and traumatic, as well as general surgery, interested in private practice where could do fair amount of general work and of major surgery.

Mundy, Charles B., M.D., Dahlgreen, Va., born New York City, married, Protestant, graduate New York University School of Medicine, 1950, in active duty with U. S. Navy, desires to practice in community of less than 4,000 in Georgia, as general practitioner, available as soon as notified.

Olley, James Francis, M.D., Crawford W. Long Hospital, Atlanta, Ga., age 32, married, Protestant, graduate Jefferson Medical College of Philadelphia, 1945, military service fulfilled, specialty—pathologic anatomy and clinical pathology, clinic or hospital preferred, available July 1, 1954.

Paddock, Robert L., M.D., St. Luke's Methodist Hospital, Cedar Rapids, Iowa, interested in obtaining a location in Georgia suitable for a partnership with Dr. W. D. Regester, available July 1, 1954, general practice, graduate of College of Medical Evangelists in Los Angeles, Calif.

Pittard, M. D., M.D., 1945 Wilford Drive, Brookhaven, Ga., age 27, married, Methodist, graduate Emory University School of Medicine, 1950, at present in the Navy, will be discharged in August, 1954, interested in general practice, clinic, available September 15, 1954.

Porter, Gordon, M.D., 29 Rosebery Place, St. Thomas Ontario, Canada, age 55, married, Canadian, Baptist, graduate Queens University, 1921, residency Chief of Staff—Chief of Surgical Staff, Memorial Hospital, St. Thomas, Ontario, specialty—anesthesia, size of community unimportant, prefers industrial or institutional, now available.

Ranson, Robert F., Captain, MC, Laboratory Service, Rodriguez Army Hospital, Fort Brooke, Puerto Rico, at present in armed forces, graduate University of Oklahoma School of Medicine, 1947, residency in Pathology at same hospital, resident in pathology at Charity Hospital in New Orleans, at Brooke Army Hospital, Sam Houston, Texas, available within six months.

Regester, W. D., M.D., St. Luke's Methodist Hospital, Cedar Rapids, Iowa, interested in obtaining a location suitable for a partnership with Dr. R. L. Paddock, available July 1, 1954, general practice, graduate of College of Medical Evangelists in Los Angeles, Calif.

Rowe, Daniel H., M.D., 418 Purdue Avenue, Orlando, Fla., age 34, married, Presbyterian, graduate Louisiana State University Medical School, 1943, residency Boston City Hospital, at present in air force, specialty Ob-Gyn, desires community in Georgia as an associate or to establish own practice, available April 1, 1954.

Rummel, William David, M.D., 1680 Northwest Boulevard, Columbus, Ohio, age 28, married, graduate Hahnemann Medical College of Philadelphia, 1948, served as general resident at Westmoreland Hospital, Pennsylvania, began ophthalmology residency at Ohio State University in March, 1952, Diplomate of the National Board, desires position as an associate with a Diplomate of the American Board of Ophthalmology, available July, 1954.

Sharpe, Joseph H., M.D., Roswell Park Memorial Hospital, Buffalo, N. Y., born Checotah, Okla., single, Episcopal, graduate University of Oklahoma, 1947, residency at VA Hospital, New Mexico, General Hospital, New York, reserves USN, specialty general surgery, desires community in Georgia, available August 1, 1954.

Sigman, Cheney C., M.D., 1962 Johnson Ferry Road, Apartment 1, Chamblee, Ga., age 26, married, priority 4, Lutheran, specialty—pediatrics, graduate Emory University School of Medicine, 1952, pediatric residency will be completed in July, available July 1, 1954.

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Sturman, Herman G., M.D., 2700 West 15th Place, Chicago 8, Ill., age 27, married, Jewish, graduate University of Illinois, 1950, residency Mt. Sinai, Chicago and Cook County Hospital, Chicago, priority 4, specialty—Ob-Gyn, prefers community in Georgia, desires Ob-Gyn as assistant or associate or clinic, available June, 1954.

Todd, B. Harris, M.D., Philadelphia General Hospital, Blockley Division, 34th Street and Currier Avenue, Philadelphia, Pa., age 30, married, priority 4, graduate Medical College of South Carolina, 1951, residency in medicine to be completed in June, 1954, at Philadelphia Hospital, prefers general practice in small community, available June, 1954.

Tolbert, Louis E., Jr., M.D., Powder Springs, Ga., age 28, married, Presbyterian, graduate University of Tennessee College of Medicine, 1950, priority 4, general practice, available immediately.

Ullmann, Karl H., M.D., 301 Queens Road, Charlotte, N. C., graduate University of Munich School in 1949, is now chief resident in surgery at St. Joseph's Hospital and staff physician at Southwest Tuberculosis Hospital, Tampa, Fla.

Wachtel, Andrew S., M.D., The Hospital U.S. Soldiers' Home, Washington 25, D. C., age 29, married, Baptist, on military duty in Army, graduate Baylor University School of Medicine, 1950, presently completing military tour, desires community in Georgia, industrial or as assistant or associate, available July 1, 1954.

Wornas, Christian G., M.D., 4504 Pine Street, Apartment 107-A, Philadelphia, Pa., age 30, married, Protestant, graduate Marquette University School of Medicine, 1946, specialty—internal medicine, desires community in Georgia, available June, 1954.

Ambery, Sebastian, 613 Blondeau Street, eokuk, Iowa, age 43, American, married, Protestant, graduate University of Zurich, Switzerland, 1937, residency, Glenwood, specialty—proctology, priority 3, interested in general practice in community in Georgia.

Beckel, Frank, M.D., Univ. of Pittsburgh School of Medicine, Department of Pathology, Pittsburgh 13, Pennsylvania, age 35, married, graduate Duke University (pathology), priority 4, desires community in Georgia, available July-September 1954.

Cain, Robert T., M.D., 236 Clem Road, Sam Houston Village, San Antonio 9, Texas, age 30, married, one child, Protestant, graduate Emory University School of Medicine, 1953, at present taking rotating internship, prefers community with hospital facilities in Georgia or a clinic, desires to go in with another man if possible—as associate with another younger man or as assistant on temporary basis, available July 15, 1954.

Albea, John M., M.D., Apt. 108, E. Wherry, Fort Campbell, Kentucky, age 29, married, Protestant, graduate Tulane Medical School, 1952, presently an Army Medical Officer, interested in general practice in Georgia, available August 1, 1954.

Berry, Reginald V., M.D., US Naval Hospital, Pensacola, Florida, age 47, married, Protestant, graduate Yale Medical School, 1932, residency Duke University, North Carolina; U. S. Naval Medical Center, Maryland, interested in psychiatry and neurology in Georgia (clinic, assistant associate or institutional), available July-August 1954.

Bogges, Neil D., Jr., M.D., Greenville, General Hospital, Greenville, South Carolina, age 27, married, Methodist, graduate Emory University School of Medicine,

1953, licensed in Georgia, veteran, interested in general practice in Georgia, available July 1, 1954.

Burleson, Robert J., M.D., 1442 Fourth Avenue, SW, Rochester, Minnesota, age 35, married, Christian Church, graduate University of Louisville, 1943, completing 3½ years orthopedic fellowship, Mayo Foundation, priority 4, interested in orthopedic surgery in Georgia, as an assistant or associate, available October 1, 1954.

Cole, Kennety M., Jr. M.D., 1501 Harlandale Avenue, Dallas 16, Texas, age 30, married, Presbyterian, graduate John Hopkins University School of Medicine, 1951, residency Jefferson Davis Hospital, Texas, one year surgery residency, presently in practice, wishes to relocate due to inadequate income, exempt from military service, interested in general practice in Georgia, in community of any size, available May 1, 1954.

Coleman, Julian B., M.D., US Naval Air Facility, Weeksville, Elizabeth City, North Carolina, age 33, single, Protestant, graduate McGill University, 1952, priority 4, size of community not important, in clinic or as an assistant or associate, available July 15, 1954.

Dickes, Richard E., M.D., Saginaw General Hospital, Saginaw, Michigan, graduated from University of Michigan Medical School, 1953, interning at Saginaw General Hospital, interested in practicing in Georgia.

DuBose, Bolling S., Jr., M.D., 617 West Pine Street, Johnson City, Pennsylvania, age 30, married, 3 children, Presbyterian, graduate Bowman Gray School of Medicine, 1946, board eligible—internal medicine, presently in practice, wishes to relocate and enter private practice, specialty—internal medicine, desires location in Georgia, available June 1954.

Fitz, Thomas E., M.D., 1053 Oakland Avenue, Rock Hill, South Carolina, age 32, married, 3 children, Presbyterian, graduate Duke University School of Medicine, 1949, specialty—internal medicine and cardiology presently in practice, wishes to relocate due to economic status, desires group or associate practice, available two or three weeks after location secured.

Glassman, Dan, M.D., 400½ Main Street, Point Pleasant, West Virginia, age 43, married, Jewish, exempt, graduate Rush Medical College, 1935, residency at St. Francis Hospital, Charleston, interested in general practice in Georgia, available summer or fall of 1954.

Hunter, Robert, M.D., Hartford Hospital, Hartford, Connecticut, age 32, married, Episcopal, graduate Columbia University College of Physicians and Surgeons, 1943, board eligible—ob-gyn, prefers small clinic or an association, available July 1, 1954.

Lamb, James W., M.D., 906 Monroe Street, Vicksburg, Mississippi, age 38, married, Baptist, graduate Tulane University School of Medicine, 1938, residency Kansas City General Hospital, 4 year fellowship in general surgery, priority 4, specialty—general surgery, available July 1, 1954.

Maxwell, George A., M.D., 818 Thayer Avenue, Silver Springs, Maryland, age 32, married, Presbyterian, graduate University of Maryland Medical School, 1944, residency Maryland General and St. Agnes Hospitals, passed Part I, American Board of Ob-Gyn, wishes to locate in a relatively small town where sailing is readily available, prefers associate, available anytime.

McFarland, Wesley L., M.D., Mid State Baptist Hospital, 2000 Church Street,

Nashville, Tennessee, age 29, married, Baptist, graduate Tulane University School of Medicine, 1953, priority 4, interested in general practice in community in Georgia, clinic acceptable, available July 1, 1954.

MacKavanagh, James L., M.D., 160 Marion Avenue, Marrick, L. I., New York, age 44, married, Roman Catholic, graduate Georgetown University Medical School, 1934, presently in general practice, wishes to relocate, priority 3, interested in general practice in Georgia, size of community not too important, available within two or three months after location is selected.

Meador, John D., M.D., 315 Lakeview, Pineville, Louisiana, age 32, married, Protestant, graduate Louisiana State University Medical School, 1949, residency Huey P. Long, Charity Hospital, priority 4, interested in general practice in Georgia (clinic, assistant, associate or industrial) available July 1, 1954.

Moseley, Arthur J., M.D., Apt. 1D Woodland Terrace, Columbia, South Carolina, age 29, married, graduate Emory University School of Medicine, 1947, board qualified in internal medicine, recently released from active military duty, residency at Grady Memorial Hospital in internal medicine, available June 1, 1954.

O'Quinn, S. E., M.D., E. A. Conway Memorial Hospital, Monroe, Louisiana, age 30, single, Methodist, graduate University of Michigan, 1949, completed two years active duty with Air Force, completing second year of general practice residency, interested in general practice with surgery, available any time after March 1, 1954.

Retterbush, William C., M.D., Knoxville General Hospital, Knoxville, Tennessee, age 30, married, Catholic, graduate Ohio State University, 1947, priority 1-C Disc., interested in general surgery in Georgia, part time industrial to supplement private practice, available September 1, 1954.

Scruggs, W. H., M.D., Bryson City, North Carolina, age 65, married, Baptist, graduate University of Maryland, 1913, prefers small town with hospital facilities, limited general practice, licensed in Georgia, home town in Waycross, Georgia, 1 year in TB work, 3 years in general surgery, available anytime during the next three months.

Spriggs, John B., M.D., 1208 West 6th Street, Silver City, New Mexico, age 39, married, graduate University of Michigan, 1941, residency US Marine Hospital, Maryland, specialty—surgery, presently in practice, wishes to relocate due to economic situation of area, priority 4, desires community in Georgia, available June 1, 1954.

Taber, Richard P., M.D., Department of Pediatrics, University Hospital, Ann Arbor, Michigan, age 30, single, Presbyterian, graduate University of Rochester Medical School, 1948, residency Buffalo Children's Hospital, N. Y.; University Hospital, Michigan, priority 4, interested in pediatrics in Georgia, available July 1, 1954.

AVAILABLE LOCATIONS

Abbeville, South Carolina—Needs general surgeon, two general practitioners, 50 bed hospital, good facilities. Office space available. Housing, schools good. (pop. 5,000). Contact: Mr. Sam A. McAvan, Chairman of Board, Abbeville County Memorial Hospital, Abbeville, South Carolina.

Apalachicola, Florida—Small, well operated county hospital. New modern doctors building for rent, which is well equipped. Doctor-surgeon desired. Contact: G. Cecil Gibbs, Chamber of Commerce, Apalachicola, Florida.

Arlington, Georgia—(Calhoun County) In need of surgeon for practice in the new Terrell County Hospital (28 beds). Contact: Mr. W. B. Bostwick, Arlington City Hospital, Arlington, Georgia. (pop. 1,382).

Attapulgus, Georgia—(Decatur County) Present doctor unable to practice on a full scale, and would like to have another physician to keep up the work. Has clinic with waiting rooms for white and colored patients, x-ray, cardiogram, metabolism, pneumothorax, violet ray, and laboratory equipment. Town is centrally located with access to hospitals. Will reserve working space in the clinic, and will sell outright or lease the clinic at very nominal figure. Will cooperate and assist any doctor coming to this town. (pop. 500) (county pop. 22,234) Attapulgus, Georgia.

Austell, Georgia—(Cobb County) Excellently equipped 16 bed hospital with first rate facilities in nearby Marietta and Atlanta. Contact: Dr. J. G. Bussey, Austell Hospital, Austell, Georgia. (pop. 1,230).

Bainbridge, Georgia—(Decatur County) Office furnished and available now. Need general practitioner. Contact: Dr. Henry A. Bridges, 402 S. West Street, Bainbridge, Georgia. (pop. 7,562).

Broxton, Georgia—(Coffee County) Doctors clinic available, also home. 60 room county hospital at Douglas. 7 room doctors building. Contact: Mr. L. L. Denton, Sr., P. O. Box 198, Broxton, Georgia. (pop. 890).

Cairo, Georgia—(Grady County) Grady County Hospital at Cairo, 31 beds. Suitable office facilities with exam room, etc., available reasonably. Houses available for purchase or rent. Needs two physicians. Contact: Mr. Louis A. Powell, P. O. Drawer 387, Cairo, Georgia. (pop. 9,500).

Clarkston, Georgia—(DeKalb County) Needs general practitioner. Offices available rent free. Contact: Mrs. M. E. Flow-ers, Clarkston, Georgia. (pop. 1,165).

Conyers, Georgia—(Rockdale County) Hospital clinic now in process of being built between Conyers and Millstead. Office space can be rented reasonably. Houses can be rented or bought. Contact: Mr. O. J. Bradford, Conyers, Georgia. (pop. 2,004).

Crawford, Georgia—(Oglethorpe County) Two hospitals in Athens. Office space available for rent. Housing can be arranged satisfactorily. Contact: Mr. C. A. Townes, Crawford, Georgia. (pop. 10,000).

Dawsonville, Georgia—(Dawson County) Have a modern well equipped health clinic. Arrangements for an office can be made without difficulty. No physician in county. (pop. 500) Contact: Mr. Carlton Gilleland, Mayor City of Dawsonville, Dawsonville, Georgia.

Douglas, Georgia—(Coffee County) New Hill-Burton Hospital (65 Beds) Office space available for rent. Housing can be arranged. Need pediatrician, surgeon, diagnostician. Contact: Dr. T. H. Clark, Douglas, Georgia. (pop. 10,000).

Hampton, Georgia—(Henry County) Hospital in Griffin. Office space, housing available. Contact: Mr. A. L. Cain, Cain's Pharmacy, Hampton, Georgia. (pop. 1,000).

Hawkinsville, Georgia—(Pulaski County) Has a 40-bed hospital. Two suites being built for doctors office. Contact: Mr. W. N. Pate, Chairman, Taylor Memorial Hospital, Hawkinsville, Georgia. (pop. 3,342).

Homerville, Georgia—(Clinch County) Offices available without charge. Private hospital. Contact: Mr. E. K. Avriett, Homerville, Georgia. (pop. 1,787).

Lakeland, Georgia—(Lanier County) One hospital in county. Plenty of office space. Housing is available. Doctors to take over operation of new hospital. Contact: Mr. J. B. Powell, Lakeland, Georgia. (pop. 1,502).

Leesburg, Georgia—(Lee County) Office space available, free. Houses for rent reasonable. Home large enough for office. No physician in county. Contact: W. F. Faircloth, Ph.G., Leesburg, Georgia.

Logansville, Georgia—(Walton County) Legion completing a doctors building. Six room houses available. Contact: Dr. Chas. S. Floyd, Logansville, Georgia. (pop. 700).

Lumber City, Georgia—(Telfair County) Nice brick office building. New hospital in same county. Five room and bath office, rent free for two years. Contact: Mr. T. D. Wooten, Wooten Drug Company, Lumber City, Georgia. (pop. 2,500).

Meigs, Georgia—(Thomas County) Available clinic with all facilities. (pop. 927) Contact: Dr. J. N. Isler, Meigs, Georgia.

Midville, Georgia—(Burke County) Has an 8 room clinic. Nice 3 bedroom home. Clear from \$15,000 to \$20,000 annually. Contact: Mr. J. Rife English, Midville, Georgia. (pop. 682).

Newnan, Georgia—(Coweta County) Excellent opportunity for Negro physician. All hospital facilities and privileges granted by white doctors. Modern housing, good schools, churches. Contact: Dr. G. P. Kinnard, Newnan, Georgia. (pop. 8,218).

Newton, Georgia—(Baker County) Hospital in Camilla, 9 miles away. Can rent or purchase an office. Apartments for rent. Contact: Mr. R. F. Mulford, Newton, Georgia. (pop. 503).

Pearson, Georgia—(Atkinson County) Will furnish house, and equip clinic. New Hill-Burton Hospital at Douglas (15 miles) guarantees staff privileges to GP. Office will be rent free for six months. Contact: Mr. Barney Kraft, Pearson, Georgia. (pop. 1,402).

Rockmart, Georgia—(Polk County) Needs two general surgeons, GP. Beautiful Rockmart-Aragon Hospital, 25 beds. Good manufacturing industry. Housing available reasonably. Great need for surgeon. (pop. 4,000). Contact: Dr. J. E. Griffith, Rockmart, Georgia.

Smithville, Georgia—(Lee County) Home in Leesburg, office downtown. Completely equipped office of 2 rooms and connecting lavatory and toilet with outlets for sterilizers, etc., attached. All private practice available. Contact: Mr. Chas. A. Dean, Smithville Drug Store, Smithville, Georgia. (pop. 700).

Snellville, Georgia—(DeKalb County) Office and home under construction. rent free. Community will support doctor. Contact: Mr. Ralph Head, Snellville, Georgia. (pop. 500).

Temple, Georgia—(Carroll County) Office space available. Either rent or purchase home. Two hospitals easily accessible from Temple. Contact: Mr. L. G. Lyell, Temple, Georgia. (Pop. 900).

Tifton, Georgia—(Tift County) Local hospital available. Housing available at reasonable cost. Need GP and EENT. Contact: Mrs. Agnew Andrews, Tifton, Georgia. (pop. 15,000).

Thomson, Georgia—(McDuffie County) Office space in modern building, steam heat, air conditioned. Can supply office furniture if necessary, carpets for floors, etc. Can also supply janitor service. Contact: Mr. G. C. Fite, Knox Building, Thomson, Georgia. (pop. 3,100).

Unadilla, Georgia—(Dooly County) Hospital in county. Office space available or will build small clinic and let doctor rent or buy. Housing will be provided, rent or buy. Guarantee a good doctor will do well. Contact: Mr. E. H. Conner, Unadilla, Georgia. (pop. 1,200).

Warner Robins Air Force Base, Georgia—(Bibb County) Vacancy for a medical officer (occupational medicine) GS-12, \$7,040 per annum. Also for medical officer (general supervisory) GA-13, \$8,360 per annum. Contact: Karl McPherson, Chief, Civilian Personnel Division, Warner Robins, Air Force Base, Warner Robins, Ga.

Warthen, Georgia—(Washington County) Office space available for rent. Full time physician would have more work than he could do. Contact: Mrs. Macon Warthen, Warthen, Georgia. (pop. 200).

Watkinsville, Georgia—(Oconee County) \$5,000 loan available to doctor interested, free to construct office, rent free. Contact: Mr. Frank E. Stancil, Watkinsville, Georgia. (pop. 800).

Whigham, Georgia—(Grady County) New clinic. Housing available, buy or rent. 52,000 raised for physician to locate in Whigham. Contact: Mr. N. Z. Trulock, Whigham, Georgia. (pop. 700).

Winder, Georgia—(Barrow County) 40-bed hospital recently opened. Office space available for rent. Adequate housing available. Need GP's, surgeon. Contact: Mr. W. C. Harris, Winder, Georgia. (pop. 4,604).

Atlanta, Georgia—To General Practicing Physician and/or druggist. Complete active and profitable drug store with fountain and lunches, also offices in rear for physician. Doctor-owner is leaving the city and will turn over to purchaser all patients. General practice is producing cash income in excess of \$1,000.00 per month, in addition to charge accounts, the doctor represents four industrial accounts also. Call Mr. Kessler—CH. 6940 or LA. 6891; Corbin & Company, 815 Candler Building, Atlanta.

Doraville, Georgia—(DeKalb County). Hospital in nearby Chamblee, small clinic in Doraville for rent. New homes being built \$8,950.00 up. Grammar-high school. Social and recreational facilities. Population sufficiently large enough to support physicians. (County pop. 30,900). Contact: Mr. George W. Walker, City Clerk, Doraville, Georgia.

Villa Rica, Georgia—(Carroll County) New 24 bed HB hospital to be built soon. Now have seven bed hospital. Office available for lease, reasonable. Housing available at reasonable cost. 12 grade accredited school. (Pop. 3,200). Contact: Mr. Edgar P. Candler, Villa Rica, Georgia.

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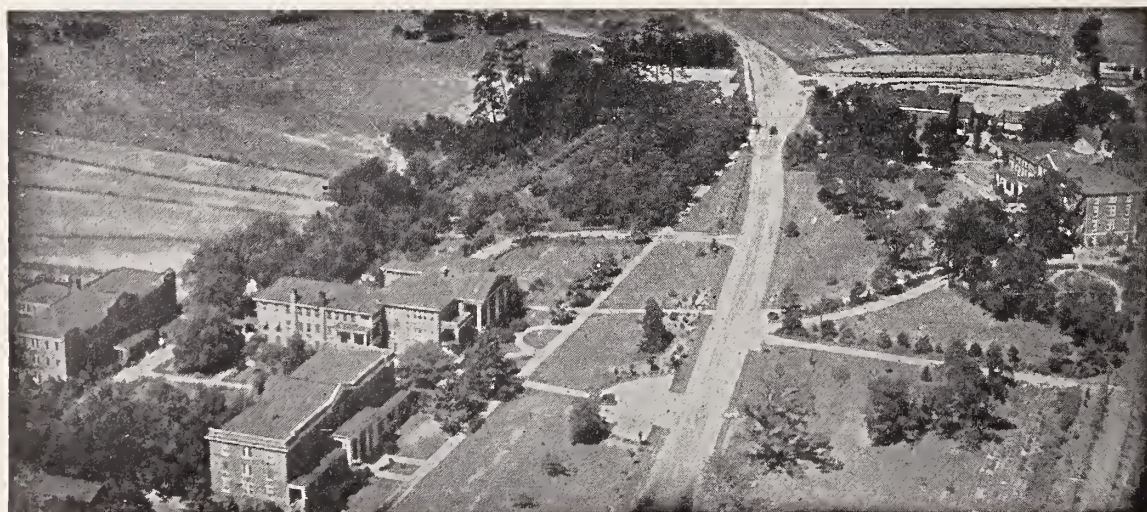
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Report of Meeting of Executive Committee of Council

MEMBERS ATTENDING THE Executive Committee of Council Meeting, held at 2:30 p.m., February 23, 1954, Academy of Medicine, Atlanta, were as follows: W. P. Harbin, presiding, Harry L. Cheves, Mark S. Dougherty, Jr., George Dillinger, and David Henry Poer. Also in attendance were Peter B. Wright, Marion C. Pruitt, Mr. Milton D. Krueger, Mr. John F. Kiser, and Mrs. Myrtice Mulligan.

Matters discussed from the agenda were: 1. Professional conduct, ethics and Association policy. 2. Association support of enforcement of the present narcotics law. 3. Progress report of the 1954 Annual Session program, Macon, May 2-5. 4. Proposal concerning MAG headquarters office building improvements. 5. Appointment of Council committee to consider and make recommendations on the request submitted by the MAG Civil Preparedness Committee Chairman Dunstan: re MAG Council assuming administrative responsibility in the medical service branch of the Georgia Civil Defense Health Services Division as coordinator in the Councilor Districts. 6. MAG participation in the State of Georgia Boards as set up by law by the Georgia legislature. 7. Discussion of the present status of the MAG voluntary insurance plan and possible future policies.

The following action was taken:

1. *Recommended* that the Association go on record as approving complete cooperation with the pharmacists of Georgia in regard to the writing and not telephoning of narcotic prescriptions.

2. *Recommended* that the Executive Secretary transmit a letter to all members of Council for their approval, disapproval or deference of the proposed MAG headquarters office space expansion. Marion C. Pruitt, representing the Fulton County Medical Society Building Committee, advised the Executive Committee of all the details involved in the proposed expansion. He asked that Council submit to the Fulton County Medical Society a building plan and an equitable arrangement to finance it.

3. *Recommended* that Dr. Cheves immediately appoint a committee to consider the feasibility of Medical Civil Preparedness Committee Chairman Dunstan's recommendation.

The meeting was adjourned at 4:50 p.m.

Subsequent to the action requested in recommendation No. 2, the letter concerning the proposed expansion of the MAG headquarters office was transmitted to all members of Council. At this time, those members replying have approved the proposal.

An Apology to Doctor Reese

Several months ago when it was learned that Dr. D. S. Reese had ceased to be Secretary of the Carroll-Douglas-Haralson Society, the headquarters office immediately took note of this fact and set about to pay him tribute for many years of faithful and efficient service. After all, good county secretaries are still hard to find, and anyone who had done so much more than his share of the work, over such a long period of time, deserves more than a simple thank-you.

In order to get the facts straight in regard to dates and other items, one of the staff wrote directly to Dr. Reese and requested such information.



D. S. Reese, M.D.

Dr. Reese cooperated as he always had throughout his secretaryship and supplied us with the essential data. Let me repeat, this was done at our request.

Unfortunately, when this letter came in, a member of our JOURNAL staff classified it as a "Letter to the Editor," and it appeared erroneously in that section of the March issue. Of course that created a very wrong impression of the situation, making it appear that our devoted friend had written in such a letter unsolicited, this was not the case.

Our deep apologies go to Dr. Reese, and I hope this will correct the wrong that has been done him. We still consider him to be a powerful member of our Association, whose influence has always been for the good, and we sincerely hope he remains active for many more useful years.

The Editor

Report of

Local Arrangements Committee General Chairman

104TH ANNUAL SESSION, MACON, GA.

PLANS FOR the 104th Annual Session of the Medical Association of Georgia were started early in June, 1953.

At the first meeting, which was held at Hotel Dempsey, in Macon, were David Henry Poer, Mr. Sid Wrightsman, Jr., and Mr. Milton Krueger, representing the Medical Association of Georgia, and Milford B. Hatcher, Henry H. Tift, and Willard R. Golsan, representing the Bibb County Medical Society. Mr. Tom Greene and Mr. Spencer E. Llorens represented the Macon Chamber of Commerce.

At this meeting, initial plans for the 1954 meeting were made and the definite date set. Following the meeting, a tour was made of the various meeting places.

Your Chairman, after this meeting, selected the various sub-committees and named a chairman for each committee.

These committees began functioning at once. Hotel reservations began coming in in June, 1953. These reservations were handled jointly by the Macon Chamber of Commerce and the Hotel Reservations Committee which is headed by Leon D. Porch.

The Macon Chamber of Commerce reserved the Macon Auditorium with three meeting rooms, the Kilowatt Room, and the Blue Flame Room, giving us ample space for all sections of the Convention. These sites had been inspected and found suitable by the committee representing the Association.

Early in November, 1953, the Entertainment Committee, headed by Thomas L. Ross, Jr., booked a name orchestra and floor show for the President's Dinner to be held at the Idle Hour Country Club in Macon.

On January 19, 1954, the Local Committee met with Mr. Milton Krueger, in the Macon Hospital Library, to discuss in more detail the programs, the sites of the various meetings, specialty luncheons, etc. This was a very successful meeting and much was accomplished. It was decided to have a similar meeting every two weeks until

final plans were made. Details of the Convention were discussed, decisions were made, and workable plans were made in these meetings.

Representatives of the Woman's Auxiliary to the Bibb County Medical Society were present and many of their problems were discussed, acted upon, and, when practical, were coordinated with the Association. The Macon Chamber of Commerce had a representative at each of these meetings also. Similar meetings should definitely be held in planning future conventions.

In order to eliminate last minute confusion in setting up exhibits, both medical and commercial, it was requested that the number of electrical outlets, line voltage, location, etc., be furnished the Executive Secretary by all exhibitors well in advance of the meeting. This information would then be turned over to the electrical contractors so that suitable wiring could be installed. This will allow the exhibitors to prepare their exhibits more quickly. The Auditorium was secured for Saturday, May 1st, so that work could begin before the Convention started.

The division of the Convention into Sections, with each Section meeting in a different area, has created quite a problem in regard to visual aids as each Section must have a set up of viewing boxes, projectors, and operators for projectors. If this system is continued, it is suggested that the Association purchase a sufficient number of projectors to adequately set up the various Sections.

The matter of dividing the Convention into Sections has not been too popular with those I have talked to on the subject. Many believe the Convention is too small for this division and that it defeats the purpose of a State Convention where many of those attending are General Practitioners from small communities and like to get as much out of the Convention as possible. They cannot attend all the specialty groups and miss many of the papers by outstanding visiting doctors who could give them valuable instruction.

In order to try to prevent the confusion at the various general luncheons and dinners held in the

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1. Cowart, E. C., Jr.: Mississippi Doctor 29:278 (April) 1952.
2. Sayer, R. J., et al.: Am. J. M. Sc. 221:256 (March) 1951.
3. Knight, V.: New York State J. Med. 50:2173 (Sept. 15) 1950.
4. Trafton, H. M., and Lind, H. E.: J. Urol. 69:315 (Feb.) 1953.



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past and to try to help the Local Committee on arranging these affairs, a questionnaire was mailed to each member of the Association in regard to whether or not they would attend. If this questionnaire is answered promptly, much help will be gained.

The Luncheon Meeting to be held this year on Wednesday, May 5th, was suggested by David Henry Poer and, in my opinion, is an excellent idea as it will hold many doctors who here-to-fore have left at Noon on the last day. I

think this Luncheon Meeting should be continued.

It has been a pleasure to work with the various committees, the Macon Chamber of Commerce, Dr. Poer, and Mr. Krueger. They have been most cooperative and have helped us in many ways to plan and put on what we hope will be a successful Convention.

Willard R. Golsan, M.D.
General Chairman
Macon

Report of Mental Health Committee Meeting

ATTENDING THE organizational meeting of the new MAG Committee on Mental Health at 2:30 p.m. Thursday, March 11, 1954, at the Academy of Medicine, Atlanta were J. R. Shannon Mays, Macon, Chairman; T. G. Peacock, Milledgeville; Paul Scoggins, Commerce; Guy V. Rice, Atlanta and Mr. John Kiser, MAG Assistant Executive Secretary.

The following action was taken:

1. *Recommended* that the Committee meet with the MAG Insurance Board to consider the possibility of including treatment for mental and nervous illness in hospital and medical prepayment plans, and *Authorized* Mr. Kiser to contact officials of private insurance companies and Blue Cross and Blue Shield representatives to obtain their views on this matter.

2. *Approved* the formation of the Georgia Study Commission in Research and Training in Mental Health by the Southern Regional Education Board and *offered* the support of the MAG Committee on Mental Health.

3. *Approved* the goals of the State Sanitarium Committee's Sub-Committee which is studying mental health facilities in the state of Georgia; and *Recommended* for the Sub-Committee's particular attention, consideration of more modern and humane laws providing for commitment of persons to the state mental hospital and that persons being discharged from the state hospital be automatically restored to a state of sanity upon certification from the superintendent of the hospital to the

county ordinary. And *Authorized* Mr. Kiser to offer the support of the MAG Committee on Mental Health to the Sub-Committee.

4. *Recommended* that the MAG Committee on Mental Health meet with the MAG Committee on Legislation to discuss possible changes in the medical practice act to include "mental illness" and "psychotherapy" as being within the legal definition and responsibility of the practice of medicine.

5. *Recommended* that in all general hospitals be made at least one sound-proof and secure room to house emergency cases of acutely insane persons awaiting commitment to a mental institution, and where psychiatrists are available, general hospitals set up in-patient and out-patient services for the early treatment of the mentally ill.

6. *Approved* sponsorship of programs for postgraduate education of physicians in the utilization of psychiatric principles in the practice of medicine. These programs would be presented by medical schools, the state hospital and any general hospital with sufficiently large psychiatric facilities.

7. *Approved* the manner in which the Child Guidance Centers have been operated by the State Health Department and *Recommended* that state and federal funds be increased to support this service.

8. *Recommended* increased budgets for mental institutions and an increase from \$2.00 to \$2.50 per patient per day level for patient maintenance.

Resolution on The Death of Harry Milton Kandel

BIRTH and death are not of our choosing. Some are more fortunate in the manner of passing than others. The sleep of unconsciousness in a matter of a very few minutes blotted out the intense headache of a massive cerebral hemorrhage in our friend and fellow physician, Dr. Harry M. Kandel, who died on January 4, 1954.

Harry Milton Kandel was born on September 6, 1898, in Savannah, Georgia. He attended Savannah Public Schools, graduating from Savannah High School. In 1921 he graduated with a B.S. Degree from the University of Georgia, and in 1926 from the University of Georgia School of Medicine with the Degree of Doctor of Medicine. From 1926 to 1927, he interned at the Savannah Hospital (now the Warren A. Candler Hospital), and entered the private practice of medicine in Savannah in June 1927.

During the course of his medical career, Dr. Kandel did postgraduate work at the University of Chicago, Harvard Medical School, and the University of Minnesota. He was a Fellow of the American College of Physicians, a Fellow of the American College of Anesthetists, a member of the American Medical Association, the Medical Association of Georgia, the Georgia Medical Society, and the Military Surgeons of America.

Dr. Kandel was interested in sports and served as doctor for the Savannah High School football team for about 19 years, and was also a Medical Examiner of the Georgia State Boxing Commission.

Patriotism and love of country were manifested by Dr. Kandel's intense interest in military affairs. Although initially rejected for military service, he persisted in his desire to serve his country in time of war and entered active military duty in the

Army Medical Corps on August 26, 1942. Most of his service was spent in hospital medical services in the United States and in the Asiatic-Pacific Theatre. He was released from active duty in 1946, but continued his military career in the United States Army Reserve. He commanded the 332nd Medical Group (Reserve) most capably, becoming recognized by higher headquarters for the superior manner in which he commanded his unit. For the past three years his unit has received superior ratings at its annual inspection. In grateful recognition of his efforts in behalf of military preparedness, a Certificate of Achievement was recently presented to him from Lieutenant General Bolling, Commanding General, Third Army, Atlanta, Ga.

Dr. Kandel aptly demonstrated the kindly family physician by the love and respect tendered him by his patients, who called upon him at all hours and at inconvenient times for advice from an understanding heart as much as for medicine from his medical bag.

Therefore, be it revolved by the members of the Georgia Medical Society, now assembled, that the untimely death of Dr. Harry M. Kandel has brought a heavy loss to the Society in the passing of a worthy past president, a loyal member, and a physician much loved by his patients and highly respected by the members of his profession.

Be it further resolved that a copy of this resolution be incorporated in the minutes of the Georgia Medical Society in tribute to his memory and that a copy be sent to his wife, Mrs. Harry M. Kandel.

Respectfully submitted,

W. Barron Crawford, Jr.

L. M. Freedman

Jacob Rubin

John G. Zirkle

Emory Centennial Celebration

The centennial year of the Emory University School of Medicine will be recognized in a special two-day celebration next October 4 and 5. The chairman of the centennial committee is Daniel C. Elkin, chairman of the department of surgery.

The Emory medical school, with headquarters

in the new \$2,500,000 Woodruff Memorial Building, grew from the Atlanta Medical College founded in 1854. Now enrolling 285 students, the school has graduated 4,649 doctors in its 100-year history and has become one of the South's centers for medical education and research.

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*English, A. R., et al.: *Antibiotics Annual (1953-1954)*,
New York, Medical Encyclopedia, Inc., 1953, p. 70.

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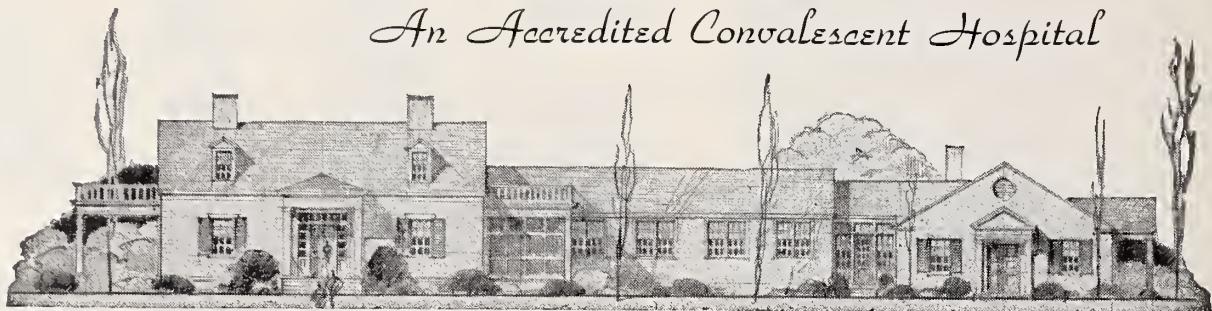
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The Financial Status of The Association

David Henry Poer, M. D.
Treasurer

Recently it was erroneously pointed out that no financial statement of the Association had been published in the JOURNAL in recent years. In 1951 the complete audit of Ernst & Ernst was published in toto in the May issue of the JOURNAL, pages 229-234. In 1952 (May, page 218) and 1953 (June, pages 282-283) summary statements were published in the proceedings of the House of Delegates, following complete reports given before that body of the Association.

Council, by virtue of the authority given it by the Constitution and By-Laws, is responsible for all financial activities of the Association, and each member is furnished a complete audit upon completion directly by the firm of Ernst & Ernst Company, Atlanta. Also, for the first time in the history of the Association (so far as printed records show), a budget has been prepared for the operation of the headquarters office during the past two years.

Beginning in 1953, the fiscal year of the Association ended on December 31st and an audit was completed following that date. Copies of this audit are in the hands of all councilors and will be reported to the House of Delegates in the proceedings in the June issue of the JOURNAL.

Since the statements shown below are balances of March 31st 1952-1953, it seemed of interest to show a comparative figure for March 31st 1954. You will note the bank balance of \$49,657.11 which should indicate that financial condition of the Association is as good (even better in many regards) as it ever has been. No withdrawals have ever been made (and *could not* be made without approval of the House of Delegates) from the fixed funds (Building, Pension, Lecture) during the past three years.

Each member should know that the books of the Association are always open for his inspection at any time.

FINANCIAL STATEMENT

Statement of Assets and Liabilities—By Funds

The Medical Association of Georgia
MARCH 31, 1952

	General Fund	Benevolent and Building Funds	Abner W. Calhoun Lectureship Fund	Combined
ASSETS				
Cash	\$52,773.23	\$ —	\$ 202.44	\$ 52,975.67
Securities owned	—	63,320.00	5,535.50	68,855.50
Accounts receivable	3,778.35	—	—	3,778.35
Office furniture and equipment	—	—	—	—
—Note A	3,824.62	—	—	3,824.62
Total Assets	<u>\$60,376.20</u>	<u>\$63,320.00</u>	<u>\$5,737.94</u>	<u>\$129,434.14</u>
LIABILITIES				
Accounts payable:				
Public relations department	\$ 110.09	\$ —	\$ —	\$ 110.09
Woman's auxiliary	10.50	—	—	10.50
General	6,521.80	—	—	6,521.80
Total Liabilities	<u>\$ 6,642.39</u>	<u>\$ —</u>	<u>\$ —</u>	<u>\$ 6,642.39</u>
Excess of Assets over Liabilities	<u>\$53,733.81</u>	<u>\$63,320.00</u>	<u>\$5,737.94</u>	<u>\$122,791.75</u>

Note A—Office furniture and equipment shown above does not include items purchased prior to April 1, 1949.

Note B—During the year ended March 31, 1952, \$800.00 was paid from the General Fund which was properly payable from specified funds as follows:

Abner W. Calhoun Lectureship Fund (Dr. D. A. Wright for lecture at annual meeting	\$200.00
Benevolent Fund (pension)	600.00
Total	<u>\$800.00</u>

Statement of Income and Expense—By Funds

The Medical Association of Georgia
YEAR ENDED MARCH 31, 1952

	General Fund	Abner W. Calhoun Lectureship Fund	Combined
INCOME			
Membership dues	\$23,619.00	\$ —	\$23,619.00
Net income from the Journal	8,222.29	—	8,222.29
Fees from exhibitors, less expense of annual meeting, \$2,418.36	6,556.64	—	6,556.64
Interest on savings share acct.	204.87	—	204.87
Interest on U. S. Savings Bonds	1,250.00	—	1,250.00
Dividends on stocks owned	—	222.02	222.02
Total Income	<u>\$39,852.80</u>	<u>\$222.02</u>	<u>\$40,074.82</u>
EXPENSES			
Salaries	\$13,408.25	\$ —	\$13,408.25
Trustees fees	—	10.88	10.88
Administrative and other expenses	18,826.65	—	18,826.65
Total Expenses	<u>\$32,234.90</u>	<u>\$ 10.88</u>	<u>\$32,245.78</u>
OTHER INCOME			
AMA dues collected for remittance	\$ 3,837.50	\$ —	\$ 3,837.50
Withholding tax collected for remittance	598.68	—	598.68
Received from AMA for services	434.23	—	434.23
Other income—miscellaneous	107.30	—	107.30
.....	<u>\$ 4,977.71</u>	<u>\$ —</u>	<u>\$ 4,977.71</u>
Net Income	<u>\$12,595.61</u>	<u>\$ —</u>	<u>\$12,816.75</u>

Statement of Assets and Liabilities—By Funds

The Medical Association of Georgia

MARCH 31, 1953

	General Fund	Benevolent and Building Funds	Abner W. Calhoun Lectureship Fund	Combined
ASSETS				
Cash	\$33,740.83	\$ —	\$ 226.63	\$ 33,967.46
Securities owned —at cost		63,320.00	5,535.50	68,855.50
Accounts receivable	1,933.27	—	—	1,933.27
Office furniture and equipment Note A	3,598.75	—	—	3,598.75
Less allowance for depreciation	758.42	—	—	758.42
	<u>\$ 2,840.33</u>	<u>\$ —</u>	<u>\$ —</u>	<u>\$ 2,840.33</u>
Prepaid annual meeting expenses	1,015.00	—	—	1,015.00
Total Assets	<u>\$39,529.43</u>	<u>\$63,320.00</u>	<u>\$5,762.13</u>	<u>\$108,611.56</u>
LIABILITIES				
Accounts payable \$	633.05	\$ —	\$ —	\$ 633.05
Withholding and pay roll taxes	883.95	—	—	883.95
Deferred income: Membership dues	11,328.75	—	—	11,328.75
Exhibitors' fees—1953 annual meeting	5,480.00	—	—	5,480.00
Unearned subscrips to The Journal	5,802.56	—	—	5,802.56
	<u>\$22,611.31</u>	<u>\$ —</u>	<u>\$ —</u>	<u>\$ 22,611.31</u>
Total Liabilities	<u>\$24,128.31</u>	<u>\$ —</u>	<u>\$ —</u>	<u>\$ 24,128.31</u>
Excess of Assets over Liabilities	<u>\$15,401.12</u>	<u>\$63,320.00</u>	<u>\$5,762.13</u>	<u>\$ 84,483.25</u>

Note A—Office furniture and equipment is stated at cost and does not include items purchased prior to April 1, 1949.

Statement of Income and Expense—By Funds

The Medical Association of Georgia

YEAR ENDED MARCH 31, 1953

	General Fund	Benevolent and Building Funds	Abner W. Calhoun Lectureship Fund	Combined
INCOME				
Membership dues	\$21,303.75	\$ —	\$ —	\$21,303.75
Net income from The Journal— as shown by schedule	2,197.45	—	—	2,197.45
Fees from exhibitors at 1952 annual meeting, less expenses of meeting of \$5,738.55	3,391.45	—	—	3,391.45
Interest on savings share account	228.78	—	—	228.78
Interest on U. S. Savings bonds	—	1,250.00	—	1,250.00
Dividends on stocks owned	—	—	235.52	235.52
	<u>\$27,121.43</u>	<u>\$ 1,250.00</u>	<u>\$ 235.52</u>	<u>\$28,606.95</u>
EXPENSES				
Salaries	\$14,660.54	\$ —	\$ —	\$14,660.54
Trustees' fees	—	—	11.33	11.33
Administrative and other expenses— as shown by schedule	26,078.71	—	—	26,078.71
	<u>\$40,739.25</u>	<u>\$ —</u>	<u>\$ 11.33</u>	<u>\$40,750.58</u>
	<u>\$13,617.82</u>	<u>\$ 1,250.00</u>	<u>\$ 224.19</u>	<u>\$12,143.63</u>
OTHER INCOME				
Profit on equipment sold—net \$	807.48	\$ —	\$ —	\$ 807.48
Received from A.M.A. for services, postage, etc.	474.78	—	—	474.78
	<u>\$ 1,282.26</u>	<u>\$ —</u>	<u>\$ —</u>	<u>\$ 1,282.26</u>
Net Income—				
Deficit	<u>\$12,335.56</u>	<u>\$ 1,250.00</u>	<u>\$ 224.19</u>	<u>\$10,861.37</u>

Italics indicate red figures.

Net Income From The Journal

The Medical Association of Georgia

YEAR ENDED MARCH 31, 1952

INCOME			
Advertising			\$17,500.42
Subscriptions			12,013.50
		Total Income	\$29,513.92
EXPENSES			
Salaries	\$ 3,300.00		
Publication	17,991.63	21,291.63	
		Net Income	\$ 8,222.29

Net Income from The Journal

The Medical Association of Georgia

YEAR ENDED MARCH 31, 1953

INCOME			
Advertising			\$18,612.97
Subscriptions			10,761.44
		Total Income	\$29,374.41
EXPENSES			
Salaries	\$ 6,601.48		
Publication	20,575.48	27,176.96	
		Net Income	\$ 2,197.45

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SOCIETIES

TENTH DISTRICT MEDICAL SOCIETY met recently in Athens where the Annual Golf Tournament was held in the morning. Those reading papers at the afternoon symposium on Kidney Diseases were Arthur Merrill, William Caton, B. Friedewald and Joseph Wilson, all of Atlanta. The meeting was concluded with a social hour and banquet.

CHEROKEE-PICKENS MEDICAL SOCIETY met at the home of Dr. and Mrs. C. J. Roper in Jasper. After completion of business, the group had dinner at the Lenning Hotel. Officers elected were Ben Keith Looper, Canton, president; W. H. Perrow, Jasper, vice president; Arthur Hendrix, Canton, secretary-treasurer. Delegates to the Annual Session are E. A. Roper, Jasper, and T. C. Boswell, Tate.

FULTON COUNTY MEDICAL SOCIETY met recently at the Academy of Medicine in Atlanta.

Principal speaker was Samuel Kaplan, senior research associate at the Cincinnati College of Medicine, who talked about the "mechanical heart" which he helped develop. A resolution was passed which stated the members "must withhold endorsement of the present plans for construction (of Grady Hospital) until given an opportunity to consult properly with the authority in their advisory capacity."

RANDOLPH-TERRELL MEDICAL SOCIETY met recently at the home of Dr. and Mrs. J. C. Patterson in Cuthbert and elected the following officers: E. A. Mayo, Richland, president; W. G. Elliott, Cuthbert, vice president; and R. B. Martin, III, secretary-treasurer. Mrs. A. R. Sims, Richland, was elected president of the woman's auxiliary; Mrs. Marion Pugh Lumpkin, vice president; and Mrs. R. B. Martin, III, Cuthbert, secretary-treasurer.

WARE COUNTY MEDICAL SOCIETY'S March meeting was held in Blackshear. James J. Crumbly, assistant in medicine at Mayo Clinic, spoke on "Psychosomatic Medicine." Hosts for the meeting were W. A. Hendry, Katherine Hendry, G. T. Hendry, L. M. Hawkins, Tom Oden, T. C. Nation and R. A. Dodelin.

PERSONALS

OSLER A. ABBOTT, Atlanta, was the principal speaker at the annual meeting of the Chatham-Savannah Tuberculosis and Health Association on March 11. The topic of his address was "The

Development of Concepts of Treatment of Tuberculosis in the Past Twenty-five Years."

SAMUEL A. ANDERSON, Atlanta, announces the removal of his offices to 1299 West Peachtree St., N.E., for the practice of psychiatry.

A reception was given on February 23 by the people of Jasper County in honor of Dr. and Mrs. F. S. BELCHER, Monticello, to pay tribute to their service and congratulate them on their fiftieth wedding anniversary.

JEROME D. BERMAN, Atlanta, spoke to the Sandy Springs Kiwanis Club on February 19 on the "Recent Progress in the Fight Against Polio."

TULLY BLALOCK, Atlanta, has taken office as president of the medical staff of the St. Joseph's Infirmary, Atlanta.

STEPHEN W. BROWN, Augusta, is president of the board of directors of Professional Building, Inc., the group which is backing the construction of the five story doctors' building and drug store near the medical center in Augusta. THOMAS W. GOODWIN is a member of the board also.

FREDERICK D. CHENEY, Chief of Medical Services at the Dublin Veterans' Administration Hospital, attended the VA Conference following the Atlanta Graduate Medical Assembly's three day annual conference.

WILBUR D. HALL, Calhoun, addressed the Rotary Club of Calhoun on February 19; the topic of his address was "Rotary."

GUY C. HEWELL, Atlanta, announces the removal of his offices to 101 Third Street, N.E., for the practice of obstetrics and gynecology.

MILDRED NELL KENNEY, M.D., Dublin, was married to GEORGE MITCHELL LANE, M.D., also of Dublin, on Saturday, April 10, in Moultrie.

John Hamilton Maley, four-year-old son of Mr. W. C. Maley and VIRGINIA HAMILTON MALEY, Gainesville, died at Crawford W. Long Memorial Hospital, Atlanta, after an extended illness.

LOUIS MANGANIELLO, Augusta, and his wife, (Dr.) CAROL GRAHAM PRYOR, announce the birth of a daughter, Carol Helen, on December 17, 1953.

ROBERT B. MARTIN, III, Cuthbert, addressed the Cuthbert Lions Club recently on "The Treatment of Fractures."

HARRY M. McALLISTER, Atlanta, announces the opening of his office for the practice of ophthalmology at 703 Medical Arts Bldg., 384 Peachtree St., N.E.

WILLIAM MINNICH, Atlanta, presided at the dinner meeting on February 25 of the Piedmont Hospital Building Fund special gifts committee.

The dinner marked the end of the two-week special gifts campaign.

N. J. NEWSOM, Sandersville, will make an extended visit at the British Industries Fair in London following stops at other major European trading centers as a member of the New Orleans International House 18th Trade and Travel Mission to Europe.

JACK C. NORRIS, Atlanta, has been appointed a member of the Council of the Southern Medical Association from Georgia for a term of five years. He succeeds OLIN S. COFER, Atlanta, whose term expires in November.

RUFUS PAYNE, Augusta, spoke to the Kiwanis Club of Augusta on February 16 concerning the plans and future operations of the medical center now under construction in Augusta. Dr. PAYNE is director of the multi-million dollar Eugene Talmadge Memorial Hospital.

ROBERT C. PENDERGRASS, Americus, spoke to the Rotary Club February 16 on the history of the Andersonville prison during Civil War times.

A feature story about JAMES W. PILCHER, Louisville, appeared recently in the Atlanta Journal.

Mrs. Clinton Reed wife of CLINTON REED, Smyrna, died February 8 after a long illness.

C. H. RICHARDSON, Macon, spoke recently to the Macon Hospital Commission asking action to curb speed and noise of ambulances.

JAMES K. TRUMBO, Augusta, spoke in March to the Optimist Club on the treatment of persons suffering from crossed-eyes.

JOHN W. TURNER, Atlanta, president of the Fulton County Medical Society, was guest of honor at a recent meeting of the Woman's Auxiliary to that society.

R. HUGH WOOD, dean of the Emory University School of Medicine, gave the Harold Wellington Smith Lectureship at the Naval Medical School, Bethesda, Md. His topic was "Medicine in the Changing Order."

NEAL YEOMANS, Waycross, spoke to the Lions Club in March about the training and work of a radiologist. Dr. Yeomans also recently attended a meeting of the Eastern Section of Radiologists in Washington.

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The JOURNAL *of the* **MEDICAL** **ASSOCIATION** **OF GEORGIA**

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MANUSCRIPTS

Articles are accepted for publication on the condition that they are contributed solely to this *Journal*. Manuscripts should be typewritten, double-spaced and the original, not the carbon copy, should be submitted. Receipt of manuscripts will be acknowledged and unused manuscripts returned. Used manuscripts will be returned only if requested.

STYLE

Ordinarily articles should not exceed 3,000 words. Only under exceptional circumstances will articles of over 4,000 words be published. Footnotes, bibliographies and legends should be typed on separate sheets, double-spaced. Bibliographies should conform to the style of the Quarterly Cumulative Index published by the American Medical Association—i.e., name of author, title of article, name of periodicals with volume, page, month, day of month if weekly and the year. They should be listed in alphabetical order and numbered in sequence. Example: 1. Jones, S. R.: Spontaneous Epistaxis, *Arch. Int. Med.*, 36:434 (Dec.) 1946.

NEWS NOTES

District and County Medical Societies, Association members and readers are invited to send in any news items of general concern to members of the Medical Association of Georgia.

REPRINTS

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Illustrations, tables, etc., should bear the author's name and figure number. Used photographs, drawings and cuts will be returned after publication only if requested. The cost of reproduction of illustrated material for publication will be borne by the author and the engraver will bill the author for this expense.

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The Editor and members of The *Journal* Editorial Board will permit authors to have as wide a latitude as the general policy of the *Journal* and the demands on its space permit. The right to reduce, revise, or reject any material submitted for publication is always reserved. The *Journal* is not responsible for statements made by any contributor. All communications regarding editorial, advertising, subscription and miscellaneous matters should be sent The Editor, 875 West Peachtree Street, N.E., Atlanta, Ga.

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If in the opinion of the *Journal* Editorial Board, material submitted for publication could be improved by a Medical Editing Service, the Editor will contact the author for his approval. Association members needing assistance in preparation of material for publication may also use this service. A reasonable charge is made for this service and the cost of this will be borne by the author.



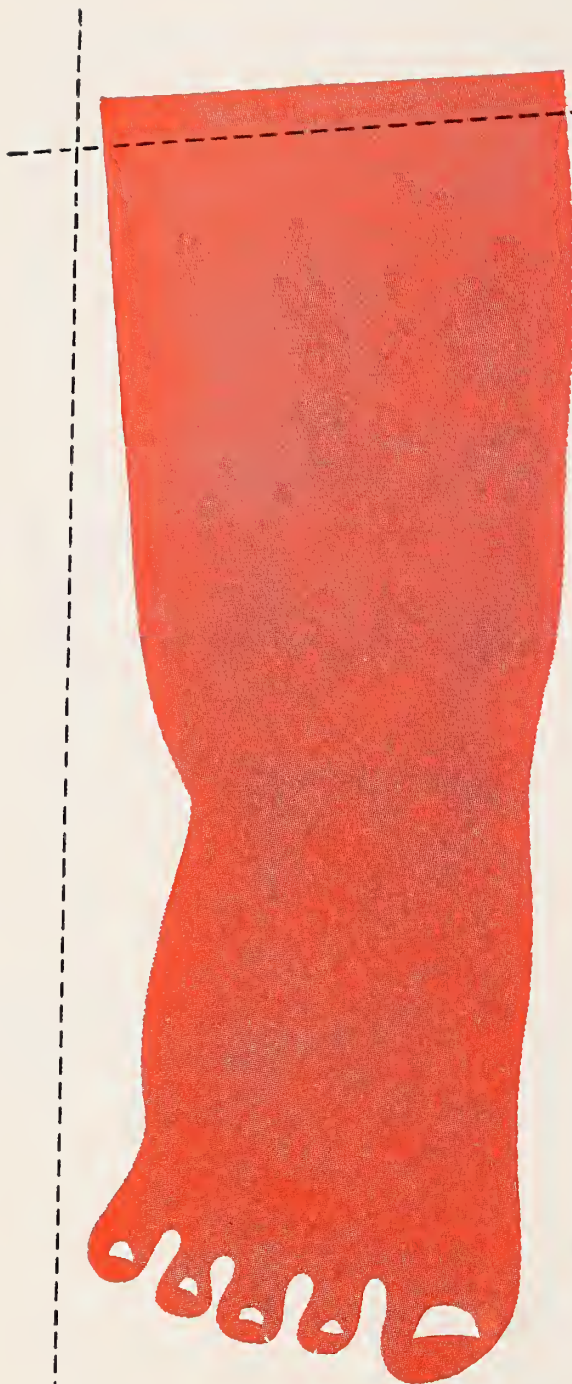
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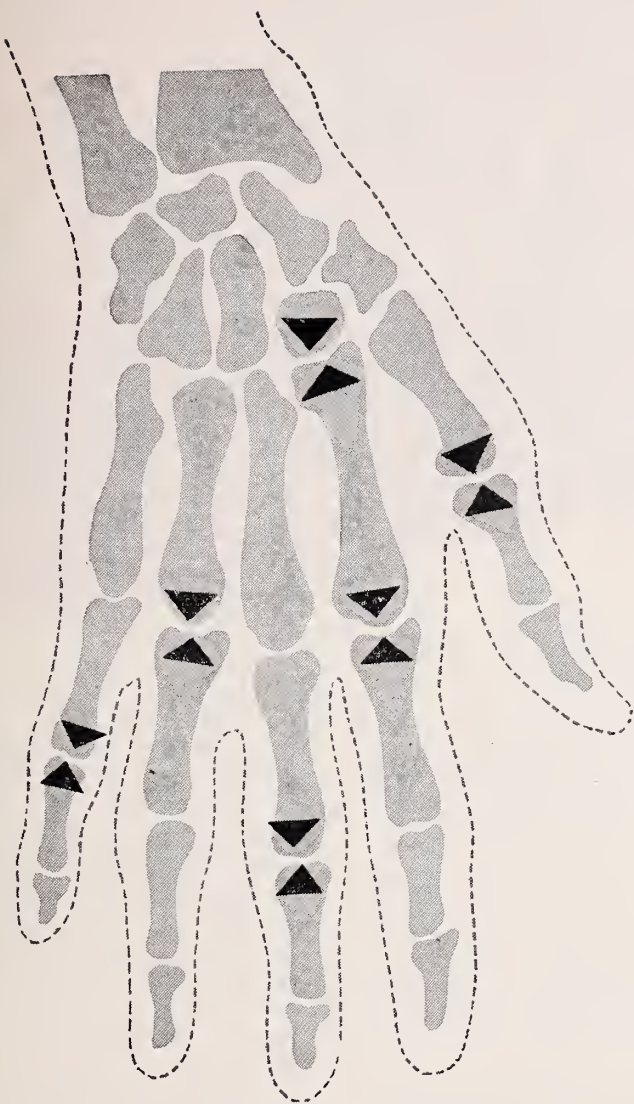
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Its usefulness and efficacy substantiated by numerous published reports, BUTAZOLIDIN has received the Seal of Acceptance of the Council on Pharmacy and Chemistry of the American Medical Association for use in:

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Since BUTAZOLIDIN is a potent agent, patients for therapy should be selected with care; dosage should be judiciously controlled; and the patient should be regularly observed so that treatment may be discontinued at the first sign of toxic reaction.

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BUTAZOLIDIN® (brand of phenylbutazone), coated tablets of 100 mg.



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DISTINCTIVE AMONG POTENT HYPOTENSIVES FOR THE

14

**DESIRABLE
PROPERTIES...**



Veriloid

A selective alkaloidal extract of hypotensive principles obtained by fractionation from *Veratrum viride*. Representing less than 1% of the whole root, it is freed from the dross of the whole substance. It is generically designated alkavervir. In the management of hypertension it presents these desirable properties:

1 Biologic assay—based on actual blood pressure reduction in mammals—assures uniform potency and constant pharmacologic action.

2 Blood pressure is lowered by centrally mediated action; there is no ganglionic or adrenergic blocking.

3 Therapy is rarely, if ever, fraught with the danger of postural hypotension.

4 Hypotensive action is independent of alterations in heart rate.

5 Cardiac output is not reduced.

6 Renal function, unless previously grossly reduced, is not compromised.

7 Cerebral blood flow is not decreased.

8 Cardiac work is not increased, tachycardia is not engendered.

9 No dangerous toxic effects from oral administration, no deaths attributable to Veriloid have been reported. Side actions of sialorrhea, substernal burning, bradycardia, nausea, and vomiting (due to over dosage) are readily over-

come and thereafter avoided by dosage adjustment.

10 In broad use over five years, literally in hundreds of thousands of patients, no other sequelae have been reported, whether Veriloid is given orally or parenterally.

11 Tolerance or idiosyncrasy rarely develops; allergic reactions have not been encountered. Hence tablets Veriloid can be given for the long treatment needed in severe hypertension.

12 Continuing therapy with Veriloid has not led to interference with appetite or with excretory function.

13 Because of its rapidly induced, prolonged action (6 to 8 hours), tablets Veriloid provide around the clock hypotensive effect from 4 doses daily, make today's dosage effective today, and usually prevent hypertensive "spiking" during the night.

14 A notable safety factor in intravenous administration: *extent to which blood pressure is lowered is directly within the physician's control.*

Tablets Veriloid

The slow-dissolving, scored tablets are supplied in 2 mg. and 3 mg. potencies. In moderate to severe hypertension they produce gratifying response in many patients. According to published reports¹ this response can be maintained for long periods in fully 30% of patients; combination with other hypotensive agents has been credited with greatly increasing this percentage.² Initial daily dosage 9 mg., given in divided doses, not less than 4 hours apart, preferably after meals. To be increased gradually, by small increments, till maximum tolerated dose is reached. Maintenance dose 9 to 24 mg. daily.

Solution Intravenous

For immediate reduction of critical elevated blood pressure in hypertensive emergencies such as hypertensive state accompanying cerebral vascular disease, hypertensive crisis (encephalopathy), toxemias of pregnancy. It lowers the blood pressure promptly, to any degree the physician desires, and with notable safety.³ Excessive hypotensive and bradycardic effects should be invoked they are readily overcome by simple means. Supplied in boxes of six 5 cc. ampuls. The solution contains 0.4 mg. of Veriloid per cc.

Solution Intramuscular

For maintenance of blood pressure in such critical instances, and for primary use in less critical situations which do not show the same immediate urgency. Provides 1 mg. of Veriloid per cc. in isotonic aqueous solution incorporating one per cent procaine hydrochloride. A single dose lowers the blood pressure significantly, reaching its maximum hypotensive effect in 60 to 90 minutes. By repeated injections (every 3 to 6 hours) blood pressure may be kept depressed for hours or days if necessary. Supplied in boxes of six 2 cc. ampuls. Complete instructions as to dosage and administration accompany every ampul of the parenteral preparations of Veriloid and should be noted carefully.

1. Kauntze, R., and Trounce, J.: Treatment of Arterial Hypertension with Veriloid (*Veratrum Viride*), *Lancet* 2:1002 (Dec. 1) 1951.
2. Wilkins, R. W.: Combination of Drugs in the Treatment of Essential Hypertension, *Mississippi Doctor* 30:359 (Apr.) 1953.
3. Stearns, N. S. and Ellis, L. B.: Acute Effects of

- Intravenous Administration of a Preparation of *Veratrum Viride* in Patients with Severe Forms of Hypertensive Disease, *New England J. Med.* 246:397 (Mar. 13) 1952.
4. Moyer, J. H., and Johnson, I.: Intramuscular Veriloid (Aqueous Solution) As a Hypotensive Agent, *Am. J. M. Sc.* 226:477 (Nov.) 1953.

ORIGINAL RESEARCH PRODUCTS OF
RIKER LABORATORIES, INC. 8480 Beverly Boulevard; Los Angeles 48, California





president's page

With confidence in my colleagues and knowing that each one is anxious to do his part toward the successful handling of medical problems in Georgia, I take over the office of President of The Medical Association of Georgia with a feeling of having substantial support.

Because of necessity, committees have been appointed for certain duties. A few changes were made, since I am aware of the fact that the same person should not be called upon year after year. However, the retiring chairmen I am sure will be willing to give advice from their experience if asked to do so.

It is my hope that the entire membership will consider the Association's problems theirs also and will lend their help wherever needed. Working as a unit we can be assured of progress and a successful year.

A handwritten signature in cursive script, which appears to read "P. H. Wright".

hospital page



TANNER MEMORIAL HOSPITAL

Carrollton, Georgia

This hospital of 37 beds was put into operation

in November, 1949. The construction of this hospital was the first hospital project approved under the Hill-Burton Program in Georgia.



MITCHELL COUNTY HOSPITAL

Camilla, Georgia

This hospital, which has a capacity of 32 beds,

was opened for the reception of patients in September, 1949. Space to permit enlargement by 18 additional beds is now under construction.



Thank you doctor for telling mother about...

- T**he Best Tasting Aspirin you can prescribe
- T**he Flavor Remains Stable down to the last tablet
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ACHROMYCIN

Hydrochloride Tetracycline HCl Lederle

A NEW BROAD-
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A SIMPLIFIED MOLECULE

ACHROMYCIN is a new and notable broad-spectrum antibiotic.

Several investigators have reported definitely fewer side reactions with ACHROMYCIN.

ACHROMYCIN maintains effective potency for a full 24 hours in solution. It provides more rapid diffusion in tissues and body fluids.

On the basis of clinical investigations to date, ACHROMYCIN is indicated in the treatment of beta hemolytic streptococcic infections, *E. coli* infections, meningococcic, staphylococcic, pneumococcic and gonococcal infections, acute bronchitis and bronchiolitis, and certain mixed infections.

CAPSULES { 250 mg.
 { 100 mg.
 { 50 mg.

INTRAVENOUS { 500 mg.
 { 250 mg.
 { 100 mg.

SPERSOIDS* { 50 mg.
Dispersible { per teaspoonful
Powder { (3.0 Gm.)

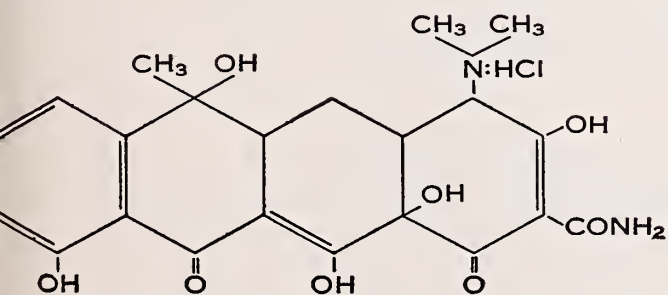
Other dosage forms will become available as rapidly as research permits.

*Reg. U.S. Pat. Off.



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EYE, EAR, NOSE AND THROAT

A three months combined full time refresher course consisting of attendance at clinics, witnessing operations, lectures, demonstration of cases and cadaver demonstrations; operative eye, ear, nose and throat on the cadaver; clinical and cadaver demonstrations in bronchoscopy, laryngeal surgery and surgery for facial palsy; refraction; radiology; pathology; bacteriology and embryology; physiology; neuro-anatomy; anesthesia; physical medicine; allergy; examination of patients pre-operatively and follow-up post-operative in the wards and clinics; attendance at departmental and general conferences. (9 mos.)

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A combined course comprising attendance at clinics and lectures; instruction in examination, diagnosis and treatment; witnessing operations; ward rounds; demonstration of cases; pathology; radiology; anatomy; operative proctology on the cadaver; attendance at departmental and general conferences.

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A three year course, fulfilling all the requirements of the American Board of Dermatology and Syphilology. Also five-day seminars for specialists, for general practitioners, and in dermato-pathology; attendance at departmental and general conferences.

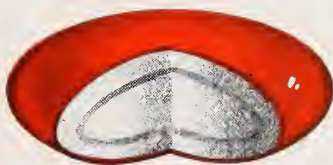
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A comprehensive review of the physics and higher mathematics involved, film interpretation, all standard general roentgen diagnostic procedures, methods of application and doses of radiation therapy, both x-ray and radium, standard and special fluoroscopic procedures. A review of dermatological lesions and tumors susceptible to roentgen therapy is given, together with methods and dosage calculation of treatments. Special attention is given to the newer diagnostic methods associated with the employment of contrast media, such as bronchography with Lipiodol, uterosalpingography, visualization of cardiac chambers, perirenal insufflation and myelography. Discussions covering roentgen departmental management are also included; attendance at departmental and general conferences.

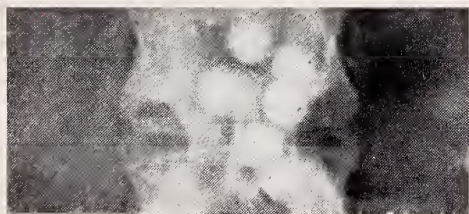
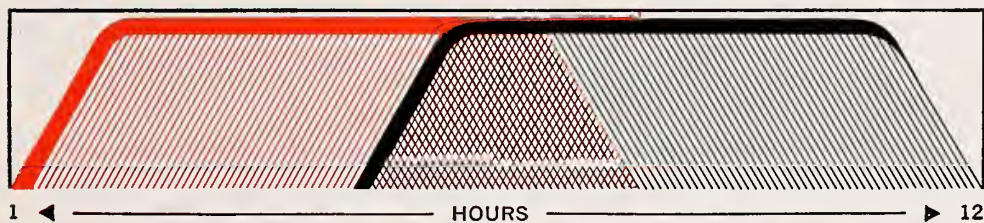
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REPETAB
assures 8-12 hours' sustained
relief in hay fever

Outer layer dissolves immediately providing rapid onset of relief



Special Timed Barrier (not enteric coating) releases inner layer for prolonged effect



Inner core still intact 2½ hours after ingestion of 6 special radiopaque REPETABS*

*Unretouched x-rays.



At 4½ hours disintegration of cores well underway—complete in four, beginning in two.*

*the **REPETAB** principle assures*
prolonged sustained relief with
single dose convenience

CHLOR-TRIMETON® Maleate, brand of chlorphenpyridamine maleate.

REPETABS,® Repeat Action Tablets.

Schering

CHLOR-TRIMETON REPETAB



Meats-in-a-Can

and Kitchen-Cooked Meats...

Comparative Nutritive Values

From a practical dietary standpoint, meats-in-a-can—preserved by commercial canning—are nutritionally interchangeable with meats of like variety prepared in the home.¹ For taste appeal, for economy and “keeping” quality, and for household con-

venience, meats-in-a-can are advantageous in many respects.

As the comparative data here shown indicate, kitchen-prepared meats and similar meats-in-a-can are closely alike in the amounts of various nutrients they provide.

COMPARATIVE COMPOSITION OF KITCHEN-COOKED AND COMMERCIAL-CANNED MEATS
(Nutrient Amounts per 100 Grams)

	*Kitchen-Cooked Ham ²	**Canned Ham ³ (Chopped, Cured)	Kitchen-Cooked Beef Round ²	Canned Roast Beef ²
Water	50%	50%	59%	60%
Protein	21 Gm.	20 Gm.	27 Gm.	25 Gm.
Fat (ether extract)	28 Gm.	20 Gm.	13 Gm.	13 Gm.
Niacin	4.0 mg.	4.3 mg.	5.5 mg.	4.2 mg.
Riboflavin	0.21 mg.	0.19 mg.	0.22 mg.	0.23 mg.
Thiamine	0.46 mg.	0.40 mg.	0.08 mg.	0.02 mg.

*Values after conversion from 42% to 50% water basis.

**Values after conversion from 58.69% to 50% water basis.

Experimental studies have shown that the processing which meats-in-a-can undergo leads to little if any greater vitamin losses than does home-cooking of similar cuts of meat. In general, meats-in-a-can retain of their original vitamin content approximately:

- 60 to 80 per cent of thiamine
- 90 to 100 per cent of riboflavin
- 90 to 100 per cent of niacin
- 80 per cent of biotin
- 70 to 80 per cent of pantothenic acid.^{4,5}

During storage for customary periods, at usual warehouse temperatures, meats-in-a-can show little, if any, further vitamin loss except in thiamine. Even thiamine, a highly thermolabile vitamin, was 52 per

cent retained in pork-in-a-can after ten months' storage at 80° F. Retention of the vitamin was notably greater when the canned pork was stored at 38° F.

Since meats-in-a-can are thoroughly cooked in processing, they may be consumed as purchased, merely warmed or mildly cooked. When the meat is moderately cooked in preparation for consumption, little or no further loss in vitamins need to occur.

Recent studies show that meats-in-a-can are excellent sources of needed amino acids.⁶ The 18 amino acids determined in these studies appeared in similar ratio and amounts in canned beef, pork, and lamb as in the respective fresh or home-cooked meats.

1. Howe, P. E.: Foods of Animal Origin, Handbook of Nutrition, American Medical Association, ed. 2, Philadelphia, The Blakiston Company, 1951, p. 637.

2. Watt, B. K., and Merrill, A. L.: Agricultural Handbook No. 8, United States Department of Agriculture, 1950.

3. Schweigert, B. S.; Bennett, B. A.; Marquette, M.; Scheid, H. E., and McBride, B. H.: Food Res. 17:56 (Jan.) 1952.

4. Rice, E. E., and Robinson, H. E.: Am. J. Pub. Health 34:587 (June) 1944.

5. Schweigert, B. S.: Am. Meat Inst. Foundation, Circular No. 8, Nov. 1953.

6. Schweigert, B. S.; Bennett, B. A.; McBride, B. H., and Guthneck, B. T.: J. Am. Dietet. A. 28:23 (Jan.) 1952.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.



American Meat Institute
Main Office, Chicago... Members Throughout the United States

The Low Calorie Diet goes to work!



For your patient who works and eats out, a diet that calls for lamb chops when lamb chops aren't on the menu is an invitation to "slip off." But a diet outline that allows for substitution leaves no excuse. And learning to fill in the details of the outline gives your patient incentive to stick to his diet.

Here's what he should learn—

That a chocolate bar doesn't equal a hamburger—except in calories. An alternative must be equivalent nutritionally as well as calorically.

That fresh fruits and vegetables such as celery and radishes make satisfying between-meal nibbles without adding too many calories.

That spices and herbs, lemon and vinegar, dill pickles and india relish add zest and variety with few or no calories.

Here's what he should do—

Keep a daily record of his calorie count—between-meal snacks included!

At cocktail parties, reach for a radish rose or carrot stick instead of a high-calorie canapé. And choose the drink that lasts a long time.

Keep his diet out of the conversation. Sympathy from friends begets sympathy for himself. And self-pity is death to a diet.

The patient who works out the details of his diet within your outline earns a bonus beyond losing weight. He learns the good diet habits that lead to a well-balanced maintenance diet later. And the pounds he takes off, stay off.

United States Brewers Foundation

Beer—America's Beverage of Moderation

104 Calories/8 oz. glass*



If you'd like reprints for your patients, please write United States Brewers Foundation, 535 Fifth Avenue, New York 16, N. Y.

*Average of American beers

LONG BEFORE HOT FLUSHES APPEAR . . .

Patients presenting such classic menopausal symptoms as hot flushes cause little diagnostic difficulty. However, throughout the period of declining ovarian function which may begin long before hot flushes appear, many women complain of distressing symptoms which though less clearly defined are actually due to estrogen deficiency. For example, insomnia, headache, easy fatigability, and symptoms affecting the bones, joints, and the skin may not be readily identified as due to estrogen deficiency because they may occur years before, or even years after cessation of menstruation.

Investigators^{1,2} have found that as the body attempts to adjust itself to declining estrogen production, a number of symptoms may appear which call for the prompt institution of estrogen replacement therapy. These symptoms may be nervous, circulatory, arthralgic, or dermatologic in character because the loss of ovarian hormone "withdraws one of the most important metabolic regulators of the organism"³ and affects many body functions. If such metabolic imbalance or deficiency is evidenced, the administration of estrogen is clearly indicated.

"PREMARIN" presents the complete equine estrogen-complex as it naturally occurs. "Premarin" not only produces prompt symptomatic relief, but it also imparts a gratifying and distinctive "sense of well-being." It has no odor . . . imparts no odor.

"PREMARIN"®



Estrogenic substances (water-soluble), also known as conjugated estrogens (equine). Available in both tablet and liquid form.

1. Werner, A.: Acta endocrinol. 13:87, 1953.

2. Malleson, J.: Lancet 2:158 (July 25) 1953.

3. Goldzieher, M. A., and Goldzieher, J. W.: Endocrine Treatment in General Practice, New York, Springer Publishing Company, Inc., 1953, p. 23.



NEW YORK, N. Y. • MONTREAL, CANADA

5405

the executive secretary's letter

That Office in Atlanta

It is important that each physician in Georgia know the organization of the state association's Headquarters Office. The annual dues paid by the members of the state association support activities of this office and their investment is considerable. These few paragraphs should give insight into the duties and function of the personnel who maintain this office.

Mrs. Myrtice Mulligan is the general secretary and office receptionist. She has been employed by the Association for 1½ years. Her duties largely consist of office stenographic work, files and filing, physician's placement service, and phone and office receptionist.

Miss Frances Porcher handles *The Journal of the Medical Association of Georgia* under the direction of the Council and the editor. Miss Porcher's duties include the second reading of all material published in the Journal, responsibility for galley proofs, illustrations, and page dummies plus the records and placement of Journal advertising. Miss Porcher has been with the Association 3 months.

Miss Thelma Franklin is responsible for membership and bookkeeping. This entails all the membership records, membership cards, county society membership reports and related correspondence. As bookkeeper, Miss Franklin is in charge of all the financial transactions of the Association under the direction of Council and the Secretary-Treasurer. Miss Franklin was employed by the Association two years ago.

Mr. John F. Kiser is the Assistant Executive Secretary of the Association and Mr. Milton D. Krueger is the Association Executive Secretary. Two men are employed in this capacity so that one of them may be in the field visiting county medical societies at all times. The duties handled by these men include committee work, annual session planning, liaison with county medical societies, and Headquarters Office program and project administration. These men, while in charge of the Headquarters Office personnel, are responsible to Council and the Secretary-Treasurer. Mr. Kiser has served the Association for seven months and Mr. Krueger has been with the Association for two years.

Five full-time people are employed in the Headquarters Office. Four of them are actually in the Atlanta office of the Association and one person works in the field as liaison between the county medical society and the state association. Their aggregate annual salaries total \$18,300 at the present time. It is Headquarters Office policy to consider these people as a team. Working closely together, with few exceptions, any member of the team can capably handle another's assignment.

Most physicians are aware of the fact that Association business has become "big business." Budget-wise the Association is a \$75,000 annual business. Administratively the Association business keeps five full-time employees working approximately six days a week. Policy-wise the Association receives hundreds of man-hours monthly rendered by physicians active in Association affairs.

Perhaps trite—but the job of the headquarters office is to serve the interests of 2,600 physicians. As such, this is a tremendous task. Georgia medicine must continue to provide the best medical care and the headquarters office staff works toward this end.

Milton D. Krueger
Executive Secretary

the month in washington

Washington, D. C.—These spring days are growing into weeks that really count in Congress. Unless a bill deals with an emergency, it had better be well on its way through committees by now or its chances of enactment will fade rapidly as summer approaches.

For good or evil, a large amount of health legislation is well advanced, and if Congress holds to an average pace several bills affecting the medical profession are likely to become law in the next month or so. Here is the situation in brief:

Medical Deductions

Legislation to increase the amount deducted from taxable income for medical expenses is a part of the omnibus tax revision bill which cleared the House early and by a wide margin, but ran into some delay on the Senate side. This bill, with the medical deduction liberalization intact, should reach the White House in plenty of time.

Hill-Burton Expansion

A move to make important changes in this bill developed in the Senate Labor and Welfare Committee, after the House had passed its version with some amendments. American Hospital Association proposed that the rather complicated House legislation be scrapped, and instead that the Hill-Burton Act be amended to (a) include rehabilitation centers and nursing homes, and (b) place a high priority on hospitals for the chronically ill. The AHA idea immediately attracted support in and out of the committee. The new approach suggested by AHA meant inevitable, but probably not fatal, delays.

Reinsurance

This proposal, once hailed as the keystone of the Eisenhower administration's health program, continued to encounter opposition. At one stage, of all the national associations to testify on reinsurance only American Hospital Association was giving it unqualified support. American Medical Association, the U. S. Chamber of Commerce, and national spokesmen for the insurance industry took about the same position: 1. Reinsurance alone cannot make uninsurable risks insurable. 2. The threat of federal control of medicine is inherent in any program that would bring the

federal government in such close contact with medical practice. Dr. David B. Allman, representing the AMA at the House hearings, emphasized that the Association would welcome and cooperate in any movement carrying real promise of promoting voluntary health insurance.

Health Grants

This is an administration plan to do away with the present categorical grants for identified projects, such as venereal disease control, and to substitute funds earmarked for three general purposes, (a) to maintain present programs, (b) to initiate new programs or to expand existing ones, and (c) to finance public or private experimental or pilot programs of national or regional significance. In both committees the question was whether to group the first and second type grants together, with the state health authorities deciding how to divide up the federal money among old and new projects. Funds for the third type grant—experimental—would be completely controlled by the surgeon general. One suggestion is to require approval of the state health officer for any experimental (type three) grant in his state. Another is to eliminate the third type grants altogether, letting the National Institutes of Health handle public health as well as other medical research grants.

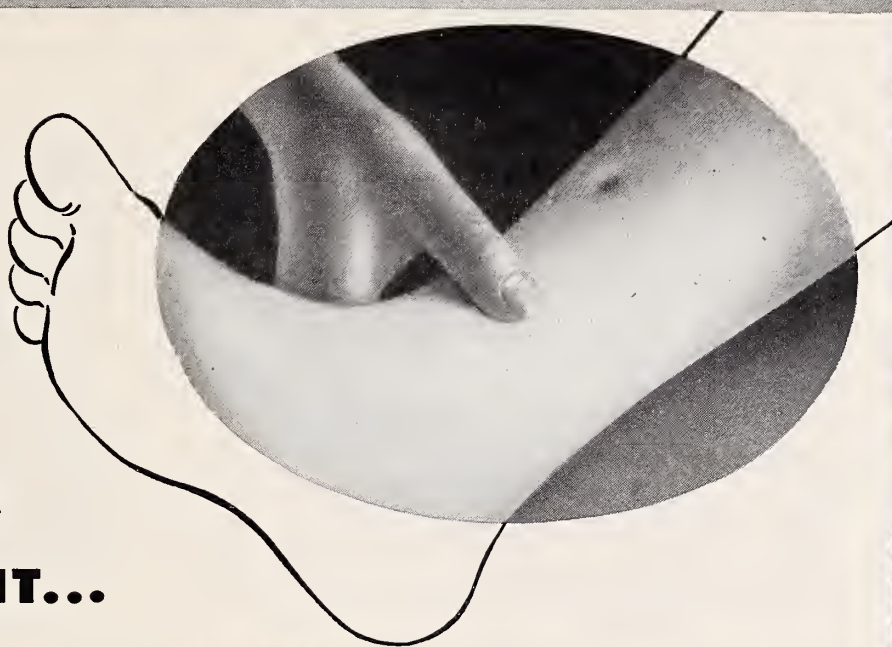
Doctor Draft Amendment

This bill, an outgrowth of the Peress case, swept through the Senate without objection. It may be law by the time this is published. It would amend the Doctor Draft act to permit the services to keep on duty as an enlisted man, assigned to professional tasks, anyone called under the Doctor Draft act whose loyalty is questioned. Defense Department has promised to investigate such cases immediately, so that the man can be cleared promptly and offered a commission or discharged. The discharge would state that action was taken on loyalty grounds.

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1. Abramson, Julius, Bresnick, Elliott, and Sapienza, P. L.: *New England Jour. Med.*, 243:44, July 13, 1950.

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MAG President-Elect



H. Dawson Allen, M.D.

The new President-Elect of the Medical Association of Georgia, Henry Dawson Allen, Jr., has been a practicing psychiatrist since 1924 in Milledgeville. Dr. Allen was born in Milledgeville May 23, 1894, the son of Henry Dawson and Sally Whitaker Allen. He is a graduate of the University of Georgia and the College of Physicians and Surgeons, Columbia University, where he received his M.D. degree in 1918. Before assuming his present position as Physician in Charge, Department for Women, Allen's Invalid

Home, Milledgeville, in 1924, Dr. Allen had been an Assistant Physician at the Manhattan State Hospital. He was also Pathologist at Milledgeville State Hospital and Commissioner of Health in Baldwin County, Georgia.

Dr. Allen holds membership in the American Medical Association, American Psychiatric Association (Life Member), Southern Medical Association (former chairman of the section on neurology and psychiatry) and he was an MAG counselor for a number of years before being elected to his present office. Dr. Allen is a past president of the Sixth District Medical Society, Baldwin County Medical Society, and the Southeastern Neuro-Psychiatric Society.

Being the well rounded man that he is, Dawson Allen has a much wider circle of interests than just his professional interests. This is evidenced by the fact that he is an active member, an officer or former officer of the following organizations: Georgia Jersey Cattle Club, American Jersey Cattle Club, Milledgeville Chamber of Commerce, Indian Island Hunting and Fishing Club and the Progressive Farmers Club. He is also a member of the Board of Directors, the Merchants and Farmers Bank.

The Macon Meeting

THE ANNUAL SESSION just ended in Macon was a total success by all standards of measurement and everyone came away intellectually stimulated and socially refreshed. Macon outdid itself as the most hospitable convention city of our state, and we are forever indebted to our friends in the Bibb County Medical Society for a constant display of attention and favors.

The varied scientific programs were highlighted by outstanding guest speakers from all parts of the United States and attendance was excellent for all sessions. Seven hundred forty-three physicians (674 members) were registered and guests and exhibitors brought this to a record number of 900 total. The 50 commercial and 31 scientific ex-

hibits filled all available space to bring these to an all time high total for the Association.

Coverage of the session by press, radio and television was complete and did much to promote good public relations for the entire profession. All of this represents good organization and preparation which had gone on for weeks in advance.

All sessions moved with smoothness and dispatch, thanks to the cooperative efforts of all presiding officers. It was a valuable and interesting experience for all of us and again Macon and Bibb County are to be heartily congratulated for perfect performance.

Now we look forward to our 1955 session in Augusta.

Elkin Wins Hardman Award

On May 5, 1954, at the 104th Annual Session of the Medical Association of Georgia in Macon, Daniel Collier Elkin received the Lamartine Griffin Hardman Award for distinguished service to the science of medicine and the medical profession in Georgia and for exceptional work in the field of vascular surgery. This is a fitting tribute to Dr. Elkin as he retires from the faculty of Emory University at the end of this academic year.

Dr. Elkin has been professor of surgery and chairman of the department of surgery in the Emory School of Medicine for 24 years. Since 1939 when it was established, he has occupied the Joseph B. Whitehead chair of surgery.

Emory President Goodrich C. White said when he accepted Dr. Elkin's decision to retire that he did so "with the utmost reluctance."

"The University," Dr. White said, "has had no more distinguished faculty member. He has been a devoted and constructive force in the development of the medical school, the Emory University Hospital, and the University as a whole."

In announcing his retirement, Dr. Elkin said that he had wanted to retire at the end of World War II. He stated that he had stayed on the job in order "to see the completion of the Whitehead Wing (Emory surgical pavilion completed in 1947), the establishment of an endowment for the department of surgery with its basic research surgical laboratory, and a beginning on the formation of the recently organized Emory University Clinic."

A native of Kentucky, Dr. Elkin spent the early part of his life on a bluegrass farm which has been in his family for over a century and to which he plans to retire. He is a nephew of the late W. S. Elkin, who was dean of the Atlanta Medical College at the time that it became the medical school of Emory University. He served as first dean of the new school.

A graduate of Phillips Academy and Yale University, from which he received the A.B. degree in 1916, Dr. Elkin won his M.D. degree at Emory in 1920. He also holds the honorary degree of Doctor of Science, awarded by Northwestern in 1952.



Daniel C. Elkin, M.D.

After his graduation from Emory, Dr. Elkin served his internship and his residency in surgery at Peter Bent Brigham Hospital in Boston, working under the late Harvey Cushing, pioneer in modern brain surgery. In 1923, he returned to Atlanta and joined the Emory staff. He was married to Miss Helen McCarty in that year and is the father of one son, Daniel Elkin Jr.

Dr. Elkin was promoted to full professorship and to chairmanship of the department of surgery in 1930. Nine years later, he became Joseph B. Whitehead professor of surgery and surgeon-in-chief, Emory University Hospital. From 1939 to

1948, he was also surgeon-in-chief of Atlanta's Grady Memorial Municipal Hospital.

In 1940, Dr. Elkin was the third man to receive the coveted Matas Medal, awarded by Tulane University for "conspicuous achievements in advancing the progress of vascular surgery." Said the citation: "You have labored continuously and fruitfully for the progress of surgery, making the surgery of the blood vessels and of the heart the chief object of your research. In this you have given enduring evidence of your technical skill and the life-saving productiveness of your labors."

His techniques and knowledge were particularly valuable in World War II when he entered the Army medical corps. He spent more than three years as chief of the surgical section and chief of professional services at Ashford General Hospital, White Sulphur Springs, W. Va. Released from active duty as a Colonel in 1946, Dr. Elkin in 1949 was promoted to the rank of Brigadier General, a rank he still holds. In 1945, was awarded the Legion of Merit for Army work.

The Mag Looks Ahead

BY THIS TIME THE 734 physicians who attended the Macon MAG Session will have had time to press their clothes, cure their headaches and return to the old office routine. Many others have learned about the Association proceedings through friends. Now we are ready to settle down for a few months of hard work before starting our plans for the Augusta Session in 1955.

No doubt all of those who attended have had the opportunity to think over the significance of the events that transpired in Macon and evaluate them in their proper perspective. First, everyone agrees that the Association is very fortunate in having men of the calibre of Peter B. Wright and H. Dawson Allen to carry on as President and President-Elect during the coming year. Likewise, our delegates and councilors are men who have shown themselves to be sincerely interested in the business of the Association, and we know they will fulfill their offices with distinction.

Perhaps it was the management of the affairs of the Secretary-Treasurer's office that created the greatest interest, as evidenced by the largest vote ever experienced by the Association (approximately 500). Much was heard about "budgets," "total assets," "salaries," and "publication of the annual audit." We believe this to be very healthy for the Association and hope that this sudden in-

terest in financial matters will not just as suddenly die away now that the course has been charted for another three years.

Three years ago in Augusta, the Association embarked on a program of reorganization of the executive offices and substantial progress has been made. Following the expression of the voters, full approval has been given this program and it will be continued on a firm basis. No further expansion is envisioned, therefore the budget need not be increased. It is already apparent that the increased revenue from dues will provide necessary income to carry on a full program of activities. The Council will see that every dollar is well spent and that the Association receives full value.

The new *Journal* also was given overwhelming approval in Macon and it will continue along the same lines of operation. It is being published within its own income and probably will continue to return a small profit.

Your officers accept your vote of confidence with a deep sense of responsibility and with a serious determination to administer the business of the Association in the most efficient and economical manner possible. Your cooperation has made progress possible in the past; it is even more necessary during the next three years.

DAVID HENRY POER

Review of Membership Policies

Since the Medical Association of Georgia is a constituent association of the American Medical Association and the national organization is looked to for guidance in matters of policy, it is essential that we conform as much as possible to the policies of the AMA. Inasmuch as the membership of the AMA is determined by the membership of the constituent associations, conformity in this phase is considered to be desirable, if not obligatory. In many respects the sections on

Membership in the Constitution and By-Laws of the MAG and of the AMA are almost identical except where different terminology is used to denote the things that are essentially the same.

The AMA divides its members into five categories: (1) Active Members, a. Dues-Paying Members, b. Exempt members, (2) Service Members, (3) Associate Members, (4) Affiliate Members, and (5) Honorary Members.

(1) **ACTIVE MEMBERS:** Membership is limited to those members of constituent associations who are eligible to vote and hold office in those associations. Active members may be excused from the payment of dues for the following reasons: financial hardship or illness, postgraduate training, retired from active practice, temporary service in the armed forces and over 70 years of age.

According to the Constitution and By-Laws of the MAG, **ACTIVE MEMBERS** are those whose names are on the official roster of a component county society *and* whose annual dues have been paid to the county society and the state association. Those exempt from paying dues as listed above except for the last are classified by the state organization as **ASSOCIATE MEMBERS**. These **ASSOCIATE MEMBERS** of the MAG are entitled to all the rights and privileges of the Association except that they shall not pay dues or receive the *Journal*.

(2) **SERVICE MEMBERS:** This group includes all full-time commissioned medical officers of the Army, Navy, Air Force, U. S. Public Health Service, Veterans Administration and Indian Service, and those physicians who have been retired from the Services by federal law and who do not engage in active practice. These members shall have the same rights and privileges as **ACTIVE MEMBERS** but shall pay no dues and receive no publications except by personal subscription.

This category has no counterpart in the MAG. All members of the Armed Forces medical services are considered **ASSOCIATE MEMBERS** of the MAG. No distinction is made between Armed Forces career men and those called up for active duty temporarily. However, regular members of the Armed Forces and members of approved medical faculties not engaged in private practice shall pay half the annual dues of the Association.

(3) **ASSOCIATE MEMBERS:** Associate Members in the AMA shall be limited to those members of constituent associations who are not eligible to active membership in their State Society and who do not have the right to vote or hold office in their constituent associations. They pay no dues.

In the MAG this classification is denoted by the term **SCIENTIFIC MEMBERS**. As our Constitution reads now these members pay no dues to the county and state organizations but may be subject to dues and assessments of the AMA. As we have seen above, however, these members are not required to pay dues to the AMA either; they do not have the right to vote or hold office in their constituent associations, i.e., the state medical association.

(4) **AFFILIATE MEMBERS:** This category applies to physicians in foreign countries and other professional people. There is no need for such classification in this state society.

(5) **HONORARY MEMBERS:** In the AMA Constitution and By-Laws, these members are limited to those physicians of foreign countries who have risen to prominence in the profession. They are elected to membership by the House of Delegates; they have all the rights and privileges of the Assembly but shall not vote or hold office.

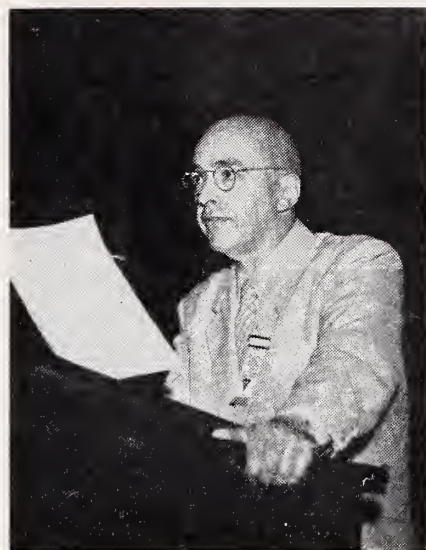
HONORARY MEMBERS of the MAG are those eminent physicians and other persons who have distinguished themselves in the science of medicine, or for human welfare. They must be nominated by a county society and approved by the Committee on Professional Conduct before being voted on by the House of Delegates. They are issued a certificate of membership without the payment of dues.

In the MAG those members who are over 70 years of age are classified as **LIFE MEMBERS**, these same members of the AMA are considered **ACTIVE MEMBERS**, exempt from the payment of dues. The state organization also accepts as **LIFE MEMBERS** those physicians who have been members of the MAG for 40 years or more. There is no provision in the AMA Constitution and By-Laws for such membership and in the state there has been a move to do away with this. This idea is not original with us; the AMA has applied a great deal of pressure to have all constituent associations conform as much as possible in this regard. In the 48 states there are approximately 53 different classifications of membership—Is there any wonder that the AMA would like conformity? If such a move were made the classification of **LIFE MEMBER** could easily be consolidated with **ACTIVE MEMBER** as in the AMA Constitution and By-Laws.

The advantages of conforming to the AMA policies are many: most important of all is the fact that the county secretaries would have some definite policy to follow which would apply to each member with regard to the state association and the national. There would be none of the duplication and contradiction we have now. The Constitution and By-Laws would be much more readable and understandable. May we repeat, inasmuch as the membership of the AMA is determined by the membership of the constituent associations, conformity in this phase is considered to be desirable, if not obligatory.

Medicine's Future

WILLIAM HARBIN, M.D., Rome, Ga.



In deciding what to talk to you about today, I have reviewed the addresses of the presidents of this Association in recent years. I did this because I am very much interested in the advice which has been given by my predecessors and also in order not to bore you with repetition. I have been impressed with the excellent discourses on the history of medicine in Georgia, the responsibilities we have as physicians, our current problems, and mixed with these, much philosophy about the practice of medicine.

Not having the age and experience of many of those who have preceded me, I am considerably handicapped in being able to reminisce about what has happened in years gone by. This has directed my attention to what the medical profession can look forward to in the years ahead. Under the by-laws of our Association it is the duty of the President to address the Association at its annual meeting and I am asking your indulgence as I say a few words about medicine's future.

Let us group those factors which influence our professional future into two main groups. First, those things over which we have no control or no more control than the average American citizen; second, those matters in which our profession has a dominant influence.

Let us discuss briefly a few of the things partly responsible for the socialized trend in government that we have and for which we, as a group, are not responsible. As our nation has prospered it has become easy for the social planners to lull the people into a state of well-being and happiness by

the promised equal distribution of those things which make our country great. The socialistic bait of something for nothing and everything done by a paternalistic government has a great appeal to uninformed and unthinking citizens. Unfortunately, the great majority of the people who have the right to vote are in this category. It was Benjamin Franklin who said, "Those who give up essential liberty to purchase a little temporary safety, deserve neither liberty nor safety." And how true we are finding this to be.

The depression of the early 1930's was the springboard from which most of our socialistic changes have come. You are familiar with these, including the designs on the private practice of medicine by the two administrations that followed. Physicians have never been blamed for the 1929 crash but the after effects have and will continue to help shape our medical destiny.

International situations beyond our control plunged us into World War II and had much to do with our participation in the Korean conflict. In the interest of national survival, regimentation that is required for total war was instituted. When peace came some, but not all, of the war regulations were discontinued, thus permitting the government to further invade the personal freedom of its citizens. Then followed a tremendous increase in the veteran population. In order to keep our country prepared to defend itself in the future, each year the number of individuals who have served in the Armed Forces has grown larger. Such changes have focused our attention on the

President's Address, 104th Annual Session, Medical Association of Georgia

part the government should play in the medical care of non-service-connected disabilities, a problem which is far from being solved at the present time. These things which have resulted from war have had, and will continue to have, their effect upon the amount of medical care which will be furnished by the federal government.

We must realize that we are struggling with the socio-economic changes in our government that have plagued other nations in centuries gone by, as they have grown and prospered. History tells us that most of the political experiments in socialism, state capitalism, and drastic social reforms have failed miserably. The details of these are well documented in the annals of our Association. The difficulty in changing this trend is well illustrated by Dr. Walter H. Judd of Minnesota, one of the outstanding members of the House of Representatives. Referring to the accomplishments of the 80th Congress, he stated that he and many other members of Congress were very proud of the fact that expenditures had been decreased, the budget had been balanced and taxes had been cut. He thought that much progress had been made towards saving the American dollar and towards saving our liberty. Then what happened? He was the only representative from a large city between San Francisco and Minneapolis, who had participated in these changes, that survived the elections of 1948.

Let us now think about those things which we, as physicians, by smart planning and action, may be able to use as strong forces in the fight for freedom in the practice of medicine. Naturally they will be of more interest to us than the influences which have just been mentioned.

The most important thing for you and for me to do is to see that our patients are happy and satisfied with the medical care they receive today. Efficient, courteous, prompt service delivered at a reasonable cost will do this job very well. In addition, we should continue the organized public relations efforts which have been of so much value in supplementing our individual accomplishments.

More complaints have been heard about the cost of private medical care than any other one feature of our present system of practice. Actually since the 1930's the percentage increase in medical costs has been much less than the increase in the cost of living, and physicians' fees have gone up less than one-third as much as industrial wages.

Better medical care has made it possible for individuals who are sick to lose less time from their work and to remain in hospitals for shorter periods. When these factors are considered it costs less to be sick now than it did 20 years ago. The voices of those who would have so-called-free government medical care have made it necessary for us to help our patients plan to budget these medical expenses. The phenomenal growth of voluntary health insurance in a short span of years has proven that this is the best method by which the average American can finance a substantial part of his cost of medical care. Almost 100 million Americans have some form of hospital and medical insurance and we are just beginning to devise ways and means of making this coverage more complete, without the benefit of government subsidy. These insurance plans should have our wholehearted support.

The profit motive in the practice of medicine has been widely criticized from without and too often abused from within. It remains the stimulus for better medical care for more Americans and cannot be surpassed by any other motive, as much as we condone its abuse. No apologies are necessary for its continuation. Without our deep sense of responsibility for the medical welfare of our citizens and without the incentive just referred to, many people would not have received the medical care they needed and wanted during World War II and in the long period of uninterrupted economic prosperity which has followed. Enough emphasis has not been put on the fact that when doctors have improved their financial status, it has usually been accomplished by hard work and efficiency. The demand for service has been such that one of your chief concerns as an individual should be the avoidance of a work load that is detrimental to your health.

In addition to the influences which I have just classified, let us consider others which cannot be easily grouped but are just as important. Let me call your attention to the medical care which is now being rendered by the government and by organizations which are essentially lay controlled. It is estimated that in 1952, 25 million people received some type of medical care from the federal government alone, and such care as is given by state and local governments would add many more millions to this figure. In 1953, there were more than 20 thousand voluntary agencies that participated to some extent in health activities, their interests varying from deciding how medical care is to be provided to the actual provision of such

care. In addition there are a number of plans for paying for and providing for medical care which are controlled by non-medical organizations. We all know that the number of people who are treated by members of the healing arts outside of our profession is considerable. These are mentioned to emphasize the competition that can be expected by private practitioners in the future.

Here in the Southeast the number of physicians per capita is lower than in the other parts of the country. As our economy continues to improve this will not be true and competition from within and from without our profession will increase as has already happened in other areas. This should make us plan to produce the best medical care at the lowest possible cost. Our success in the years to come may depend upon our ability to stay ahead in a highly competitive market. The practice of medicine is changing economically just as rapidly as it is scientifically, and we will be wise if we give quality service at a reasonable cost. This is good public relations and the key to success in a free enterprise system in which infringements have been made.

It is a happy relief not to have the administrative branch of the federal government demanding socialized medicine and we are grateful for a completely different attitude towards our problem. There was, however, a disturbing trend of thought in President Eisenhower's message on the state of the union, January 7th, with regard to human relations. The responsibility of the federal government was strongly emphasized and very little was said about what an individual can and should do for himself. The almost unbelievable growth of voluntary health insurance in a short period of time, and the progress towards comprehensive coverage which is continuing at a rapid rate, apparently did not have any significant influence on our President as to his recommendations about government reinsurance service. The proposed legislation to supplement existing voluntary health insurance is not necessary and will increase federal regulation and control. It appears that the present administration would like to remain in office and, if necessary, at the expense of private enterprise. The public is frequently encouraged to be impatient about medicine's economic progress by the selfish interests of the social planners and those who would like to remain in power. If we continue to give good service and hold our shortcomings to a minimum, we should not hesitate to present a solid front of non-participation against encroach-

ments in the freedom of medical practice. This can be done without jeopardizing the health of the American people. In the immediate future, any major socialistic health plan will have difficult sailing without the support of a majority of the physicians in the United States.

One of the bright spots on our economic horizon is the possibility of a further decrease in the cost of medical care as we discover relatively simple cures and preventive measures for many of the diseases which today involve much expense. Little do we realize what may lie ahead in this respect. The pattern of illness sets the payment problems. As chronic diseases are controlled in some measure or reduced to short term phenomena, then the task of paying for their treatment will be simplified and many of the difficulties now associated with paying for medical care will be eased, even though new problems may be expected to arise.

With the increasing interest in community health by many groups, we should play a leading part in coordinating such activities and guiding them in the right direction. By this kind of community team work we will know more intimately the problems, the hopes, and desires of our neighbors. In turn, these neighbors will better appreciate their doctors and realize that our desires for the freedom of medical practice are closely tied in not only with their health but with the happiness and liberty of their very lives. During the past year many organizations in Georgia have called upon our Association for advice and I have found that the public has the highest regard for medical leadership in all matters pertaining to health.

What then can we look forward to? Private practice in medicine has been and will be definitely influenced by social trends, some of which have not been under our control. Giving quality service which will stand competition will help to insure a continuation of free enterprise in medical practice, although no major changes appear likely in the near future. Scientific discoveries will continue to revolutionize the prevention and treatment of disease with a decrease in the cost of medical care.

It is a great privilege to be a doctor and to have an occupation from which so much personal satisfaction can be derived in our efforts to help our fellow man. I am confident we will continue to cherish the virtues which have been responsible for the high regard and esteem that has been ours in the past.

Care of the Premature Infant

HEYWORTH N. SANFORD, M.D., Chicago, Ill.

THE GREAT AMOUNT OF attention that has been centered on premature infants in recent years has been due to the fact that approximately 50 per cent of all neo-natal deaths occur in this group, although they make up only six to eight per cent of the total number of live births in the country as a whole. Furthermore there has been an increase in the incidence of premature births over the past ten years, that makes the care of these infants a problem for the physician in almost all areas of the country.

Dr. Herman N. Bundesen, Commissioner of Health of Chicago, organized 15 years ago the "Chicago Premature Plan." This plan consists of registering all premature infants with the City Health Department within a few hours after birth. The premature infant who is born at home, or in the hospital and does not have adequate premature care, is transported in an oxygenated incubator ambulance to a hospital which specializes in such care.

From 1936 to 1948 premature infant deaths in Chicago have been lowered six and one-half per cent. From 1948 to 1953 it was lowered 4.3 per cent. The full-term infant death rate during the 1936 to 1948 period has lowered about three per cent and for the last five years 1.3 per cent. Inasmuch as the premature death rate has been lowered about double that of the full-term infants, we believe this procedure has been the cause of reduction. In 1936 there were 47,000 live births in Chicago. In 1952 there were 82,000 or an

increase of 80 per cent. In this number the full-term infants increased from 45 per cent to 60 per cent, whereas the premature infants increased from 2,000 to over 6,000, or there has been about 140 per cent increase of premature infants born in Chicago during the past 10 years.

This adds a considerable increase to the number of infants for our available premature infants' beds. Where formerly we planned five premature births to each 100 full-term births, we now find prematures have increased to eight per 100 full-term infants.

Causes of prematurity are multiple births, toxemia, heart disease, syphilis, tuberculosis, infections, accidents, premature separation of the placenta and abnormalities of the reproduction tract. It is generally understood that there is a tendency toward more premature births among the Negro race than the white race. Our Negro population in Chicago has increased in the last ten years, but our increase in premature infants has not been racial. Also, many premature infants are from Caesarian birth. Obstetrics has produced more live births but at a premature level. Abnormal pregnancies also account for a much higher premature mortality, less noticed in the lower weight group.

The handicaps under which the premature infant differs from the full-term infant are immaturity of the respiratory mechanism, inability to maintain body temperature, a lowered ability to assimilate and take food and a lowered immunity to infection.

Asphyxia is one of the most important things that we have to contend with. There are two

From the Department of Pediatrics, University of Illinois, College of Medicine, 1853 W. Polk Street, Chicago 12, Illinois.



A Survey of Premature Infant Mortality in Chicago, 1936-1953

possible obstacles to obtaining proper breathing, the first is inability of the respiratory center to function. Various types of resuscitators have been used, but none is entirely successful. We have been trying phrenic stimulation similar to that used in bulbar poliomyelitis. This has not been entirely successful. While a good mechanical stimulation can be attained, it becomes useless unless the center itself will take on the work. Nothing else remains except clearing the child's air passages and giving unlimited oxygen.

The second cause of difficulty, and by far the greater, is in the lung itself. The first problem is atelectasis. This is usually a diffuse process or a combination of atelectasis and emphysema, as factors favorable to air trapping may lead to interstitial emphysema, pneumomediastinum, and pneumothorax. Occasionally, this atelectasis may be localized to one or two lobes from the obstruction of a large bronchus. In this case bronchoscopic aspiration will give immediate relief. This condition should be suspected in all instances of cyanosis occurring at birth or shortly after birth. It is necessary to rule out other causes of cyanosis such as congenital heart disease, intracranial hemorrhage, pulmonary infection, tracheo-bronchial fistula, diaphragmatic hernia and adrenal hemorrhage. This may be accomplished by a roentgenogram of the chest and is obvious if the fluoroscope indicates a lung density.

We have made it a practice to fluoroscope all of our premature infants immediately after birth, and if such a condition exists a bronchoscopist is called at once into consultation. The method used

is that of inserting an infant size bronchoscope as suggested by House and Owen.¹ Even if only the main bronchus leading to the lobe is cleared, spontaneous drainage will follow in 24 to 48 hours.

It is useless to use this method if the atelectasis is scattered over the lung area, or if more than a single lobe is involved. In these instances, we must resort to oxygen alone, or use some form of mechanical resuscitation. Bloxom's² Oxygen Air Lock was devised for this purpose. The infant is placed in an atmosphere of 60 per cent oxygen concentration and the chamber locked. The pressure is then raised to three pounds per square inch and lowered automatically to one pound. It is assumed that oxygen under pressure is better absorbed through the skin and mucous membranes, that by expansion of gases, amniotic fluid and secretions are forced from the air passages, and the infant is better conditioned for normal respiratory activity. Whether this is true or not can only be found by many trials in various hospitals.

Pulmonary hyaline membrane is a major factor in deaths from respiratory causes in the newborn period. The chief damage appears to be from plugging the alveolar ducts and producing secondary or resorption atelectasis. Analysis shows it to be of protein material while vernix is not a constant component. It may originate from amniotic fluid, and air breathing seems to be essential for its formation, as it is not found in still born infants or in those dying within one hour after birth. Miller³ believes that it is a protein exudate from injured tissues of the bronchioles and alveoli.

The symptoms begin two to three hours after birth, following normal breathing, with dyspnea, retractions of the costal margins and lower sternum, and grunting followed by cyanosis. Death occurs within a few hours after onset in many instances, while in others the condition persists for two to four days with recovery.

A new approach to this problem of pulmonary hyaline membrane and scattered atelectasis was first shown by Miller.⁴ In this a humidified atmosphere was advocated for the newborn infant, which contained a material that acted directly on the substances blocking the airways. This was first noted by the sputum-liquefying action of aerosol's in adults treated for pulmonary tuberculosis. The detergent that we have been using is "Alevaire" or Triton WR 1339, which is 0.125 per cent in combination with sodium bicarbonate 2 per cent, and glycerine 5 per cent. This is administered in the apparatus as outlined by Ravenel,⁵ consisting of a nebulizer attached to an oxygen tank. The vapor is delivered directly into a croup tent or incubator.

We have adopted these measures and have been using aerosol for the last three months. It is easy to administer, and does not seem to have any injurious effects. It has not been in use long enough to make any definite statements as to its efficacy, but our impression is that it is helpful. However, we have had some deaths from massive atelectasis, showing that it is not the complete answer to this condition, but it certainly offers at least a sensible method of approach.

The inability of the child to maintain body temperature is a very important factor, but one that has been very well met in the last few years. The type of incubator is immaterial as long as the baby is kept at optimum temperature. The baby should be easily accessible and easily seen at all times. It is also essential to use an incubator that has a spark proof thermostat, that has been approved by the underwriters. The baby should be kept in the incubator until he can hold its own temperature. This may be anywhere above four and one-half pounds.

Feeding of the premature infant has undergone no marked change in the last few years. Knowledge of food and fluid requirements is quite generally understood and applied. The studies of Madey⁶ and Dancis have shown that there is no significant impairment of protein digestion, and that protein hydrolysates have no superiority over whole casein in the feeding of premature infants.

Morales⁷ has found that high fat diets were well borne clinically if the fat was homogenized. This is simply a mechanical factor as the problem is a question of absorption through size.

This all sums up to the statement that any good feeding in the hands of a competent pediatrician is satisfactory. I must admit that I prefer breast milk. However, in a recent round table on prematurity, of the 39 pediatricians present only six used breast milk. We obtain this from maternity mothers, wet nurses, or the premature's mother. It is frozen and stored in a deep freeze. It can be kept as long as a year with safety.

The Chicago City Health Department operates a very efficient breast milk station and will furnish breast milk gratis to any premature infant in Chicago. If we happen to have an excess we give it to the City Health Department, and if we run short we borrow from them. In this way, every premature infant is sure of obtaining breast milk. It is not necessary to use complete breast milk for all premature infants. The breast milk can be diluted with equal parts of any good type of artificial food and obtain almost as good results as with pure breast milk. Very small infants or those who are sick are exceptions. These are given pure breast milk.

How often should a premature infant be fed, and how soon should they be fed? We have felt that it is a mistake to begin feedings too soon on premature infants. Certainly, in this way we never have any edema in our infants. We wait 48 hours or longer. I believe that this is now the custom in many premature centers. As to the time between feedings, we use the four hour interval, although again this is immaterial. The method of feeding depends on the training of the personnel and the ability of the baby to suck. We gavage them at four hour intervals until the weight is about four pounds, then the nurse begins bottle feedings.

The polyethylene nasal catheter as suggested by Royce appears to deserve serious consideration. I have used this in hospitals that do not have personnel trained in gavage feedings and have found it to be entirely satisfactory. It obviates the necessity for frequent passing of a gavage tube.

As to accessory fluids, a great many will give dextrose or saline between feedings. In studies we made over a ten-year-period we found that five per cent carbohydrate suppresses the amount of feeding that these children would take by suppressing hunger. By giving water by dropper between

feedings, it is not necessary to use intravenous or subcutaneous fluid injection.

Lund and Kimbel⁸ found that the premature infant received very little Vitamin A from the mother and very little reserve was stored in the liver. Clifford⁹ found that there was much better absorption of water soluble A to reach a blood level of 29 units. We should, therefore, give about 20,000 units of Vitamin A in a water soluble form.

Vitamin B, I believe, is unnecessary. Vitamin C is necessary for oxidation of amino acids as well as a guard against scurvy. There has been a tendency to increase it over the years; actually 50 mg. is sufficient. This may be given in any form as orange juice or as a multivitamin. Glaser¹⁰ has proved that the vitamin D need is not over 400 units a day, and between 400 and 800 units is adequate and safe.

The administration of vitamin K to premature infants is a routine procedure in many clinics. It has been thought for many years that the premature infant had a lower prothrombin content of the blood than the full-term infant. Actually, this idea is based on a few studies of a small number of premature infants. We thought we would correlate the prothrombin estimations that we had made on the full-term infants with similar studies on 100 premature infants.¹¹ These studies showed that there is a decrease in prothrombin content of the blood in the premature baby during the first three days of life which corresponds to the decrease observed in the full-term baby except that it is not as great and it rises faster. Like the full-term baby, the prothrombin content of the blood can be increased by the administration of Vitamin K.

In this study there were 83 premature infants who were given no Vitamin K at all and 17 who were given Vitamin K. While the administration of Vitamin K increased the prothrombin content of the blood, it had no effect on the hemorrhagic manifestations. Those premature infants not given Vitamin K had six per cent of hemorrhagic manifestations, and those given Vitamin K had 24 per cent. However, this increase was due to the fact that this group was brought in from outside the hospital and had considerable manipulation. These figures simply demonstrate that capillary fragility is an important factor in the premature infant and that the administration of Vitamin K does not materially affect the hemorrhage after it has already begun. It was also found that the

percentage of hemorrhagic manifestations was no greater in the premature infant nine per cent, than in the full-term six per cent.

There were no deaths from hemorrhage in the group not given Vitamin K and one death from hemorrhage (cerebral) in the group given Vitamin K. I never thought that cerebral hemorrhage was influenced by the speed of blood coagulation. This study shows that even when Vitamin K is given in ample amounts, cerebral hemorrhage occurs just the same.

As to the administration of minerals, the only one that need be considered is iron. We estimated the red cells and hemoglobin over a period of five years on 500 premature infants and found that the premature infant, irrespective of birth weight, suffers a reduction of hemoglobin until about ten weeks of age. There was then a static state for several weeks followed by a slow increase. The fall in hemoglobin does not depend upon the weight of the child but on the age in weeks. A large premature infant leaves the hospital before this decrease is observed, whereas a small premature infant will stay in the hospital for weeks and become anemic because it is observed at the time the maximum decrease occurs. There are many clinics that give an iron preparation after the second week of life. We estimate the child's hemoglobin and erythrocytes beginning at the third week of life and if the decrease is below 10 grams of hemoglobin, we administer iron. If it falls below nine grams of hemoglobin, we give a transfusion and then iron. About 50 per cent will need iron therapy. The simple U.S.P. iron and ammonium citrate is as good a preparation as any. This is given in 50 per cent solution, one to two drops to each feeding. We were not able to demonstrate that B₁₂ had any marked hematonic effect.

Estrogen therapy was recommended by Shelton and Varden.¹² They gave 2.5 mg. of methyl testosterone in the feedings, which was later increased to five mg. Some confirmatory articles appeared that claimed a resulting gain in weight and shortening of the hospital stay 50 per cent. We used testosterone for a year with absolutely no effect. A recent article by Seitchek and Agest¹³ on 57 premature infants reported no evidence of superior gain in weight.

A few words are necessary here about fluids and metabolic balance. At the present time, we give as few fluids as possible except by mouth, as plain water. In case of vomiting or diarrhea,

fluids are given as conditions demand. After Branning's¹⁴ report that the carbon dioxide content of the blood of the premature infant was less than that of the normal infant and that the blood organic acid content of the plasma was two or three times the amount considered normal for infancy, sodium lactate was given almost routinely to premature infants. Gamble¹⁵ questioned whether an attempt to correct this acidosis was rational. A situation that is pathologic for older babies may be physiologic for the premature infant.

Clement Smith¹⁶ found that disappearance of edema was accomplished by the loss of Na and K in the urine. Physiologically and clinically, therefore, it would not be indicated to flood the premature organism with fluids and minerals.

In regard to weight gain in premature infants, in a five-year study of 500 the following was observed. We know that a full-term baby can lose between five and ten per cent of its birth weight. The premature infant of five pounds will lose twelve per cent of its birth weight and take two weeks to regain it. The premature infant that weighs 4½ pounds will lose about 15 per cent of its birth weight and will regain it in two weeks. It will take another two weeks to gain 5½ pounds, or about a month before the baby is ready for discharge. A premature that weighs 3½ pounds will lose almost 20 per cent of its birth weight. It will continue to lose for about two weeks and will return to birth weight in four weeks. It will take two months before it will weigh 5½ pounds. With smaller prematures, the loss will be 25 per cent of their birth weight, or more than a pound. It takes a good month or more to regain this, and they will remain in the hospital for three months before they are ready for discharge. The idea of getting them out of the hospital as soon as possible is laudable, but it is important to remember that the average premature infant gains slowly, and it should remain in the hospital until it can carry on its own existence.

Congenital defects represent 10 per cent of premature mortality. The one that is most frequently discussed in the last few years is retrolental fibroplasia. This was first described by Terry¹⁷ in 1942 as a congenital persistence of the primary vitreous. Owen¹⁸ later described instances where it developed after birth as an increased dilatation of the vessels. Krause¹⁹ believes that these two forms of disease are different. The first type, or congenital, is more often associated with

cerebral and somatic defects. The second consists of eye defects alone. The increase in incidence varies in different parts of the country and even in the same city. Krause in Chicago reported 6.8 per cent in 1937 and 30.4 per cent in 1948. Our incidence was 6 per cent until 1948 when it ceased entirely.

All agree that 75 per cent are under 1600 gm. in weight. The increase is not due to saving more small premature infants, for the proportion is the same over the past ten years. Other causes given have been increased bleeding in the mother, fetal anoxia, virus disease and toxic agents. Ingals²⁰ was unable to find any correlation from the mother's prenatal history. Vitamin deficiency has been thought to be a cause. Vitamin A has not decreased the incidence and Vitamin E is not conclusive. Emulsifying agents used in water soluble vitamins, incubator lights, drugs, iron and oxygen have all been considered a cause. None has been proved.

Szewczyk²¹ has recently advised against long administration of oxygen, and the delay of transfusions until the retinal vascular tree has returned to normal. From 1942 to 1947, we cared for 101 premature infants under 1500 grams of which 6 per cent suffered from this condition. From 1948 to 1953, we cared for 549 premature infants under 2500 gms., of which 120 or 22 per cent were under 1500 gms. There were no instances of retrolental fibroplasia in any of these infants.

There was no change in the care of these babies during the nine-year period. All were fed a mixture of lactic acid milk and breast milk, except those under 1500 grams and those having feeding difficulties, which were fed pure breast milk. All were given 40 per cent oxygen for 48 hours after birth, and all under 1500 grams continuous 40 per cent oxygen from birth until they regained this weight. The average amount of oxygen for those under 1500 grams was 5,000 cu. ft. per baby. All our premature infants are given a blood transfusion if their hemoglobin falls below 10 grams, or their red cells below 3,000,000. It can, therefore, be seen that we have given plenty of oxygen and many transfusions to our premature babies. The only difference in care that might account for the lower incidence in our premature group is that we give breast milk as a feeding. Whether this contains some protective substance we do not know.

Infections are difficult to diagnose in the premature infant as there are no characteristic physical signs. In 25 infants with various infections there was no one definite diagnostic point except jaundice which occurred in half of them. The same was true of laboratory tests. There was no characteristic finding except half the above infants showed anemia and a white cell count of over 12,000. It is best to remember that if the premature infant fails to gain, vomits or has diarrhea, it may have an infection. Our treatment is to give such an infant pure breast milk and 100,000 units of depository penicillin daily, and streptomycin 0.1 gm/kg until a definite organism is found. Then the antibiotics may be changed to suit the individual organism.

Premature mortality, as reported from various clinics in the country, varies from 12.7 per cent to 22 per cent. The mortality of premature infants born outside a hospital is from 10 per cent to 15 per cent higher than those born inside a hospital. Until uniform standards of prematurity are prevalent, it is useless to make any comparisons of mortality.

1853 W. Polk Street

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Emory Men Describe New Drug

A new drug that may help to control high blood pressure in man was described at the National Society for Medical Research meeting in Atlantic City.

Dr. Arthur P. Richardson and Dr. Neil C. Moran of the Emory University School of Medicine and the National Heart Institute presented results of their study on a material made from Rhododendron leaves that is proving to be effective in lowering blood pressure in animals.

The material, "andromedotoxin", was isolated from the leaves by Dr. Evan C. Horning of the Laboratory of Chemistry of Natural Products of the National Heart Institute. The Emory researchers, after a year of testing, are convinced of the

blood pressure reducing effects of the drug.

"This is due to complex reflex actions," they explain. "The drug stimulates nerve endings in the heart and lungs and in the walls of the carotid sinuses. This stimulation causes an inhibition or suppression of areas in the brain that play an important role in the regulation of blood pressure. The end result is a reduction of the blood pressure and a slowing of the heart rate."

Scientists at the National Health Institute, Bethesda, Md., were first interested in research on Rhododendron leaves because of the toxic effects of those leaves on cattle. This led to the isolation of "andromedotoxin", and the later Emory University experiments on its effects on animals.

The Pediatrician As Family Adviser

WILLIAM H. KISER JR., M.D., Atlanta

THE PEDIATRICIAN is often consulted by the family concerning matters in which his medical knowledge is not involved. There are questions about clothes, school, camp, the distress of the family with a defective child and the perplexity caused by a behavior disorder. The purpose of this paper is to study some of the aspects of this job of family advisor. The discussion will be limited to the pediatrician's function in dealing with problems of behavior. To bring out more clearly the role of the family advisor, a comparison will be made to the more familiar role of the medical advisor.

The medical advisor has knowledge of disease. The family advisor bases his skill on knowledge of people, their relationships, family situations and on familiarity with certain syndromes which often recur. The following give some indication of the nature of family pathology:

Family A: The baby is six months old, is irritable and cries frequently at night. The mother is tired, bored with housework and worried about her husband who is worried about his job. The pathology which this family brings to the family advisor is human frailty.

Family B: Mrs. B put off toilet training of her son, he is now three years old and untrained. Mr. B is strict and insists something be done.

Family C: Mrs. C is young and pretty. She has made a boy friend of her teen age son and on one occasion went to the school dance as his date. Mr. C is stodgy and prefers to read.

Family D: Mrs. D complained that her child is unruly. It developed that she was trying to carry all of the responsibility. Mr. D doesn't help much but she thinks that he deserves to rest. On the other hand, she has a good deal of vague resentment. She became tired of putting up with this compromise situation and told Mr. D he would have to help more. The next time she put the child in the play pen she was amazed that he accepted it as a matter of course. Mr. D began helping with the groceries.

Unlike disease which is more in the framework of cause and effect, the family disturbance is a

matter of team play. It may be compared to a football team which is unsuccessful. The members of the team may not be very good players or they may not be playing together.

A child needs the exhilaration of belonging to a strong family team where life is exciting and zestful. He learns confidence in his fellow teammates. He thrives in a vigorous atmosphere and tries hard to fit in and keep up his end of the game.

Family E: This family lived with Mrs. E's mother. Mrs. E often left the two year old boy with her. Mr. E did not assume much responsibility, the child was restless, a poor eater and he bit his nails. Mrs. E looked like a tired baby sitter. The players on this team were not big enough yet to play the game of life—the son showed the effects of being on a weak team.

The signs and symptoms of family disturbance change with the age of the child. The boy in the C family had colic in early infancy, feeding problems in the first year, discipline problems at pre-school age, poor school work in grades, enuresis to eleven years and, in adolescence, delinquent behavior. It is not unusual to find several or all of these complaints in the past histories of older children. The underlying pathology all along is the interaction between the child and his weak and poorly organized teammates.

The medical advisor receives a clear and definite summons to treat an illness. The summons for the family advisor is a necessary preliminary to action. It gives him authorization to go ahead. Without this authorization, the pediatrician may be hesitant to broaden the discussion to the family situation. For example, it was made quite clear by Mrs. F when she said, "This is not medical but something I want to talk with you about. I don't seem to enjoy my baby like I hoped I would." Usually the pediatrician is presented with some complaint about the child's behavior. It is still necessary to find out if the parents really want to work on their problem. "We are both pretty upset over this," said with deep feeling, is a clear summons for the family advisor.

As in medical work, there is a period of diagnostic study. The presence of symptoms in the child is presumptive evidence of disharmony in the family. In exploring the presenting complaint with the parents, the pediatrician is watchful for more definite evidence of disharmony. This may appear in little clues such as: the wife does all the talking as if the husband is not present, they contradict each other, one says "now let me tell my side", or more obvious signs of an unsatisfactory relationship may be seen.

(Continued on Page 410)

Read before the Section on Pediatrics at the One Hundred and Third Annual Session of the Medical Association of Georgia, Savannah, May 11, 1953.

From the departments of Pediatrics and Psychiatry, Emory University Medical School, Atlanta.

WITH EACH SUCCEEDING generation since civilization began, adults have said that the younger generation was terrible. But each generation seems to have weathered the storm of the demands of its period and adjusted rather well to the conventions of society. Despite this, however, the question still arises among perplexed parents as to whether we are experiencing a greater number of adjustment problems with our children today.

This is understandable when we take even a casual look at the current literature, both medical and lay, in which we find any number of articles which suggest "the proper approach" or "the proper method" of handling the everyday problems of the child. To be sure, most of these are written with a well intentioned purpose, but with the varied opinions and suggestions offered in most instances, particularly in the lay literature, the parents are literally "infused with confusion."

The physician (and I purposely avoid the use of the word pediatrician alone because it is the concern of all physicians regardless of specialty) often finds himself in a most unenviable position in regard to this matter, for it is he who is called upon to give emotional support to young parents, by judiciously and carefully advising them about child care that is most appropriate to their individual case.

This problem is made all the more difficult when we consider that many young people today enter marriage and become parents without much more than a pitifully meager knowledge of children. Then too, war has contributed its part to the problem, with its necessary separations in the family group, frequent moving, and financial stresses. And further, the problem has been magnified by the demands of our increased pace of living.

To accurately answer the question as to whether we are having more adjustment problems with children now would be very difficult. But we could say with relative safety that we are dealing with essentially the same problems as our predecessors. The real difference seems to be that more of them are brought to the physician in an effort to get some sound advice regarding an individual problem. Then too, the general population increase must be considered.

Adjustment Problems with Children

T. E. BAILEY, M.D., Augusta, Ga.

Before mentioning some of these more common problems of adjustment, some simple basis for normal adjustment should be established. This can be done by first seeking the ultimate end to which all good adjustment leads. That end is happiness. Without good emotional adjustment happiness is an impossibility.

What then is the basis for happiness in the child? It might be narrowed down to these three factors: (1) affection, (2) security, and (3) freedom to grow and adjust at one's own pace.

These factors would not seem to need any special elaboration for they are fairly self explanatory, however, some brief qualification might be in order. One may go further to say that affection on the part of the parents for the child means their accepting him for who he is regardless of his traits, while security, to quote Dr. Bert Beverly, is the feeling of "all rightness" that the child has for his parents when they are satisfied with him.

The third factor requires a little more appraisal. All children are born with certain potentialities for emotional and intellectual growth and adjustment. It is impossible to predict the ultimate capacities of the child or the rate or pace at which he will attain them. Every child is an individual and follows his own pattern in this matter. This pattern cannot be altered to satisfy the whims or preconceived ideas of his parents. He is entitled to the privilege of growing up at his own pace and moulding his own individuality. To attempt to change this almost always leads to conflict, and many times to a tragic state of circumstances.

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What then are some of the more common problems of adjustment which we encounter? To name a few: eating, sleeping, toilet training, carelessness, destructiveness, lack of obedience, negativism, cruelty, jealousy, lying, stealing, anger, fears, anxieties, sex curiosity, etc. These and many others we have all encountered. To discuss them individually would be time-consuming beyond the limits of this presentation.

It would seem better then to view them as transient barriers over which most children will hurdle in passing along the road to normal emotional adjustment. They become problems when someone deviates from the three basic factors which were previously mentioned.

As Dr. Hilde Bruch has said, "Parenthood is and has always been a responsible task and it makes a great deal of difference whether this task is carried out with intelligence and devotion or neglect, possessive domination or ignorance.

"The teaching that parents should raise children according to an ivory tower ideal may also have an undermining influence on the child's concept of himself. Fundamentally it implies that a child's development is a monument to his parents' success or failure in being perfect, and not an expression of a child's innate capacity to mature according to and in fulfillment of his individual potentialities."

Where then lies the physicians responsibility in these matters? Simply that of being a wise and judicious counselor and adviser to those who seek his advice. Of course, every physician could not be expected to be a psychiatrist, but it is only reasonable to expect that he at least keep himself informed sufficiently on the matters of what should constitute the normal bounds of emotional adjustment and be able to recognize the common deviations from these bounds. This it seems could be accomplished with a fair degree of success, even by those only casually interested, by developing a simple common sense and practical plan of approach to the "everyday variety" of problems. The deeper and more involved problems fall within the realm of the psychiatrist and naturally should be referred there. The background for intelligently making these referrals, however, can only come from knowledge of the basic factors of emotional adjustment. It could be said that most of the adjustment problems in children do not need referral to the psychiatrist; they will respond well to advice from the family physician or pediatrician who uses common sense, understanding

and good judgment. It is up to us to filter out the more difficult ones that are beyond our scope.

In conclusion, I would like to plead for a renewed effort on the part of all of us, in developing a better understanding of the emotional problems of the younger generations entrusted to our care. For in developing this, along with patience and wise counseling, we will contribute immeasurably to a better citizenry and leadership in the community of the future.

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FAMILY ADVISOR (Continued)

Where old patients are concerned the pediatrician has formed already some impression of their strengths and weaknesses.

During this phase there is a risk that the advisor will take sides and place the blame on an individual. Each parent wishes to justify himself and seeks the approval of the doctor. It may help to recall the name of his function, he is the family advisor, he is concerned with the whole family and is not sitting as judge. He is exerting himself on behalf of the child who needs both of his parents. It is to the child's interest also that his parents develop more efficient teamwork.

The objection has been raised that seeking for disharmony is looking for the "bad in people", or "reading something into the situation", or exaggerating. It is the doctor's job to look for pathology, the heart is examined carefully for a murmur which though faint may be significant.

As the diagnostic phase proceeds there is a gradual shift from the child to the parents as people. The art of helping them in this progression is beyond the scope of this paper. Their own human frailties come more into the foreground. In a vague way they sense they are not getting as much out of life as they might. One mother said, "Maybe it's us who need help, not our boy." Now a line of action has been opened up. It is possible for the parents to work constructively on their problems. They can help each other make a better team, or where their efforts at home are not suc-

cessful, they can be referred for psychiatric assistance.

It has been traditional in pediatrics to use measures aimed at symptoms in this group of disturbances. The author has used the following expedients, to name a few: sedatives for the baby who cried at night, reduced food for the child with poor appetite, regular visits to the toilet for the child who persists in being untidy, restriction of fluid for the bed wetter and getting him up at night, remedial reading for the child who insists on failing in school, and much reassurance and "nursing" for the anxious mother.

These measures appear to "work" but then the symptoms change. This gives a false sense of security and postpones constructive action on the basic problem. It is the author's present opinion that it is desirable to bring the basic problem to light as early as possible in the child's life, so that he may have the benefit of a richer family life.

This is in line with the preventive outlook of pediatrics.

By helping the parents get their problem shaped up so they can work on it, the family advisor opens up an avenue to useful work. By declining to use expedients, he blocks a blind alley. This brings a new and powerful force into the lives of these two people.

Summary

Complaints about the child lead to the recognition that the parents are not living as effectively as they might. By helping the parents understand this and withholding palliative measures the pediatrician renders a service. He opens up a new line of constructive action for the parents. They may then turn from futile efforts to relieve symptoms, to the basic job of working on their own personal problems. This contributes to the mental health of the child.

24 Fourteenth St., N. E.

Cancer Society Activities Described

The American Cancer Society's Georgia Division is governed by a Board of Directors a majority of whom (22) are well known members of the Medical Association of Georgia. A majority of the members the Cancer Executive Committee are members of the executive committee of the Cancer Society.

Several prominent businessmen and four outstanding civic minded women are also active in directing the Cancer Society activities in Georgia.

If you gave \$100 this year to the annual fund raising crusade of the Society, here is how the Board has determined your money can best be used in the fight against cancer:

\$25 for research supervised by the national organization's research committee. Grants are made only with the approval of the Committee on Growth of the National Research Council.

\$19 for public education to get patients to recognize possible symptoms and go to their doctor immediately for examination if one occurs. Methods include literature distribution to employees in business and industry; neighborhood visits; card matches with the seven danger signals inscribed thereon; educational films; press, radio and TV materials, window posters, displays and bill boards.

\$18 for services to indigent patients. These include pain relieving narcotics which are paid for if prescribed by a physician; transportation of patients to and from State Aid clinics; dressings, bandages. Testosterone will be sent to any doctor requesting it.

Also included is care in the free home for incurable patients, Our Lady of Perpetual Help, to which the Society makes a sizeable grant each year. These services are available to indigent patients in any county whenever needed and regardless of contributions received from the county.

\$9 for professional education for doctors, dentist's and nurses. Methods include brochures on early detection which are sent free to every doctor in Georgia periodically; medical films which are available for free showing to hospital staff or Medical Society meetings; symposia conducted periodically throughout the state and fellowships given by the national medical education committee.

\$9 for special projects in Georgia which include information offices in Atlanta, Augusta, Macon and Columbus (and one is planned for Savannah). Also included is an educational project among colored people conducted by a Negro staff person.

\$7 goes to the National organization for the preparation of films, literature, displays and other materials; to promote nationwide radio programs and magazine articles; and for administration.

\$7 is set aside each year as a reserve to meet fund raising costs which may arise in the 159 counties of the State. This reserve has never yet been entirely used and the remainder is carried forward for the next year's operations.

\$6 pays for the administration of the entire foregoing program in Georgia.

Anticoagulants in Acute

CHARLES D. HOLLIS, M.D., and

IN RECENT YEARS therapeutic agents have been developed that have tended to control many of the leading causes of death. As the average life expectancy has lengthened, the proportion of deaths due to cardiovascular disease, and especially myocardial infarction, has progressively increased. No method of management has been developed which will prevent occlusive disease of the coronary arteries or definitely improve the mortality or morbidity rate once the attack has occurred. The first hope of a specific approach to the problem appeared in 1946 when Wright presented his studies of Dicumarol in humans with myocardial infarction.²⁴ The objectives envisioned by use of anticoagulants were: (1) prevention of extension of the coronary thrombus formation, and (2) prevention of systemic and pulmonary embolism by inhibiting thrombus formation in the cardiac chambers and peripheral veins. Since 1946, many detailed studies of this type of therapy have been reported. Unfortunately, in such a complex problem as this, statistical analysis of data from even a large series of patients does not automatically provide the solution. Much depends on the patients and controls selected and the final interpretation of the figures obtained.

There is good rationale in the therapeutic use of anticoagulants in myocardial infarction. If progression of the clot in the coronary artery could be prevented, chances of survival would certainly be improved. Of perhaps equal importance is the fact that thrombo-embolic phenomena have an adverse effect upon the prognosis. There are several factors in this condition that facilitate the clotting mechanism: (1) the prothrombin time shortens during the first 48 hours after the attack;¹ (2) with bed rest there is a decrease in movement of the legs and respiratory muscles with an increase in venous stagnation; (3) with the fall in

blood pressure and drop in cardiac output which frequently occurs, there is slowing of the venous flow; (4) if shock, nausea, vomiting, excessive sweating, or diuresis are present following treatment of heart failure,¹² the resulting hemoconcentration produces an increase in blood viscosity; (5) the area of endocardial injury in the left ventricle offers an ideal location for clot formation. It is generally agreed that it would be helpful to prevent clotting in the heart and in the veins. It must be decided clinically whether or not the presently available anticlotting agents can accomplish this effectively.

In order to evaluate any form of treatment one must know what would happen to the patient in the absence of that therapy. It would seem that such information would be readily available. Records of patients hospitalized before anticoagulants were in common clinical use could be reviewed, or a comparative group of patients treated by the accepted conservative means could be studied simultaneously with a group treated with anticoagulants. Myocardial infarction, however, is an unpredictable disease, with many variables that affect prognosis. Collection of an equal number of patients with the same condition does not necessarily provide a suitable group for comparison.

In comparison of mortality statistics there are considerations which should be emphasized. (1) Many deaths are sudden and unpreventable. These patients would not benefit by any treatment. (2) Reports of mortality in untreated cases range from eight to 78 per cent. Even after eliminating the few reports at the extremes, one is still left with rates ranging from 15 to 40 per cent in well-documented studies. Small differences in mortality figures then, even though statistically significant, are difficult to evaluate. One instance is cited in which there were 40 per cent deaths in the controls and 16 per cent in the treated cases. When these two groups were averaged, the mortality rate was 28 per cent. In the same hospital for several

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Myocardial Infarction

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years before anticoagulants were used, the mortality rate had been 26 per cent.²⁰ (3) The type of hospital influences the death rate somewhat. In a busy city hospital frequently only the seriously ill cases are admitted, and thus the percentage of deaths would tend to be high. In an industrial hospital probably more patients would be admitted early in the attack. The higher instance of early deaths would make the mortality rate higher. The mortality rate would be less in a private hospital where milder cases are often admitted for anticoagulant therapy which otherwise might be treated at home. Sometimes patients are admitted to veterans' hospitals for convalescence, and, consequently, the death rate might be quite low. Therefore, only control groups taken from the same hospital as the treated groups would be satisfactory. (4) Mortality figures in the same hospital show rather wide swings from year to year. Schnur¹⁹ has reported ranges over a ten year period in (a) a city hospital from 40-71 per cent, (b) a private hospital with an emergency service from 28-48 per cent, (c) a private hospital without an emergency service from 24-46 per cent, and (d) a private industrial hospital from zero-21 per cent. A control group taken from previous records might not be valid.

Evaluation of the effect on thromboembolic phenomena is just as difficult. It is impossible to establish the exact incidence of TEP*. Many episodes cannot be detected clinically. Since patients with TEP are more apt to die, neither are autopsy figures indicative of the true incidence.

Listed below are statistics from representative reports:

- (1) Mortality rate during periods before anticoagulants were used:

	<i>Number of cases</i>	<i>Mortality Rate Per cent</i>
Billings ²	240	40.4
Doscher ³	4108	23.5
Mintz ¹⁴	572	21.8
Doscher	414	15.5

*Thrombo-embolic Phenomena.

- (2) Mortality rate in controlled series:

	<i>No. of cases</i>	<i>Mortality Rate</i>		
		<i>Controls Per cent</i>	<i>Treated Per cent</i>	<i>Difference Per cent</i>
Wright ²²	1031	23.4	16	7.4
Smith ²¹	920	25.4	14.2	11.2
Kerwin ¹¹	462	29.4	17.9	11.5
Greisman ⁸	175	35.0	9	26
Shilling	120	40.0	16.7	23.3
Feldman ⁶	152	30.0	30.0	0

(The salvage rate ranges from 0-26 per cent. In the larger series variation is only 7.4-11.5 per cent)

- (3) TEP before the use of anticoagulants:

	<i>No. of cases</i>	<i>Incidence of TEP</i>
Hellerstein ¹⁰	1605	11.5 (Clinically)
Hellerstein	160	4.50 (Autopsy)
Mintz	572	9.9
Zinn ²⁵	430	21.0 (Autopsy)

- (4) TEP as a major contributing cause of death:

	<i>No. of cases</i>	<i>Incidence of TEP Per cent</i>
Hellerstein	160	26.9
Eppinger ⁵	200	27.0
Miller ¹³	210	10.0
Doscher	414	6.5
Zinn	679	8.5

(If the highest incidence is accepted TEP important in only 27 per cent of deaths.)

- (5) TEP in controlled series:

	<i>No. of cases</i>	<i>Incidence of TEP</i>		
		<i>Controls Per cent</i>	<i>Treated Per cent</i>	<i>Difference Per cent</i>
Wright	1031	26.0	10.9	15.1
Keyes	920	19.4	7.9	11.5
Kerwin	462	20.0	7.6	12.4
Greisman	175	21.0	4.0	17.0
Shilling	120	20.0	5.0	15.0
Feldman	152	8.0	5.0	3.0

(Per cent deaths in

Wright's series)

9.8 3.8 6.0
(The 6.0 per cent reduction due to TEP about the same as the overall reduction of 7.4 per cent)

In Wright's controlled series, conducted under the auspices of the American Heart Association, and in many of the other studies, the small differences in the treated and untreated groups are statistically significant. This would seem to be adequate evidence that anticoagulants are beneficial and should be used in patients with myocardial infarction. Observations have been made during clinical use of the drugs, however, that have made many physicians reluctant to accept them for routine therapy. Some of the problems that may be

encountered are illustrated by the following cases:

I. A 58 year old civil engineer, after recurrent bouts of chest pain for two weeks, was hospitalized on December 20, 1953, with findings of acute posterior myocardial infarction. Heparin and Dicumarol were started immediately. Heparin was discontinued on December 23, 1953, after the prothrombin activity had dropped below 30 per cent of normal, and the prothrombin activity was maintained constantly at about 20 per cent. On December 27, the patient began to experience pleuritic pain over the left lower chest and auricular fibrillation was noted. On December 28, with the appearance of physical signs of consolidation over the right lower lobe, a diagnosis of bilateral pulmonary infarctions was made. Prothrombin times were kept within the recommended therapeutic range. Chest x-ray on January 8 showed a triangular area of increased density, obliterating the right heart border, and fluid in the right costophrenic sulcus, providing confirmatory evidence of the presence of pulmonary infarction. The patient improved very slowly and was finally discharged from the hospital on January 18 without further difficulty.

Comment: This patient developed bilateral pulmonary infarctions after being under good anticoagulant therapy from the day of admission. It has been the experience of most clinicians in treating myocardial infarction that anticoagulants, even when used promptly and in recommended doses, do not protect all patients from embolic episodes.

II. A 55-year old highway engineer was hospitalized on February 15, 1952, because of typical pain and electrocardiographic changes of acute anterior myocardial infarction. Dicumarol therapy was instituted. The prothrombin activity on February 18 had reached 10 per cent of normal and remained at 10 per cent for the next two days. On the afternoon of February 19 he began to complain of marked weakness. On February 20 a large tarry stool was passed and hemoglobin, which had been 13.7 gram on admission, was found to have dropped to 8.0 gram. He was given two pints of blood and 72 milligrams of vitamin K intravenously. The usual regimen of treatment for peptic ulcer was begun. By February 21 the prothrombin time was normal and bleeding apparently had ceased. In retrospect, history by direct questioning revealed that the patient had been having for some time epigastric fullness and burning which was relieved by ant-

acids. The presumptive diagnosis was bleeding from an unsuspected peptic ulcer, precipitated by dicumarol therapy. On the afternoon of February 21 and for the following 48 hours the patient coughed up small amounts of bright red blood. It was felt that he had had a pulmonary infarction following rapid return of prothrombin time to normal. Superficial femoral vein ligation was performed, and the course thereafter was one of gradual recovery.

Comment: This patient bled significantly from an unexpected source when the prothrombin time was still within the usually recommended range. Not uncommonly there is profuse bleeding into the gastrointestinal and genitourinary tracts when the anticoagulant treatment is apparently well controlled. Also it should be noticed that there is a suspiciously high incidence of thromboembolism immediately following the abrupt return of the prothrombin time to normal. This occurred in this patient and in the next patient to be discussed.

III. A 51-year-old university professor, a mild diabetic, was transferred from another hospital to Emory University Hospital on October 4, 1951. Two weeks before he had developed symptoms and electrocardiographic abnormalities of acute anterior myocardial infarction. He had been treated before transfer with Tromexan, and anticoagulant therapy was continued with Dicumarol. On October 7, 1951, the prothrombin time suddenly increased to three minutes, 45 seconds. Two hundred milligrams of vitamin K₁ oxide intravenously produced a prompt drop in the prothrombin time to normal. On October 8 he began to have pleuritic pain in the right and on October 10 rales were heard over the left lung base. By October 12 there were signs of frank consolidation over the left lower lobe. Also on October 10 there was recurrence of the substernal pain, and a pericardial friction rub, heard earlier in his course, reappeared. It was believed that he had had bilateral pulmonary infarctions and possible extension of his myocardial infarction after administration of K₁ oxide. Dicumarol therapy was reinstituted and his convalescence was uneventful.

Comment: It is interesting that within 24 hours after the prothrombin time had been abruptly returned to normal that the patient had developed a pulmonary infarction. Within 72 hours there was evidence of pulmonary infarction bilaterally and extension of his myocardial infarction. Many

similar observations by different groups have led to the belief that a quick change from prolonged prothrombin time to normal predisposes to intravascular clotting and embolism.

After several years of research and wide experience in clinical use of anticoagulants in this country and abroad, three divergent viewpoints have emerged. Rytand¹⁸ contends that although it cannot be claimed that these drugs are of no value, the present evidence indicating a decrease in mortality rate might not be valid. His position is supported by the following: (1) It is almost impossible to get a series that has an identical control group because of the many variables. In Wright's series 12 per cent, according to Rytand, were treated out of turn. Since the total difference in death rate was only 7.4 per cent, this could have produced a considerable alteration in his results. (2) Representative figures show that the total death rate in myocardial infarction without treatment is about 25 per cent and about 25 per cent of these are due to TEP. Thus, if treatment were completely effective, only 6-7 per cent would be preventable, assuming that the decrease in death rate is entirely due to prevention of TEP. (3) In Hellerstein's large series the incidence of clinically detectable TEP was about 11.5 per cent. This is about the same as the incidence in the treated group in Wright's study. (4) There are definite disadvantages and limitations in the use of anticoagulants. (a) It is expensive and uncomfortable to the patient. (b) Reliable laboratory facilities must be available. (c) There are several absolute contraindications to their use, including prothrombin deficiency, blood dyscrasias, renal insufficiency, vitamin C deficiency, ulcerative lesions of the gastrointestinal tract, and bacterial endocarditis. (d) Complications are not infrequent. Major hemorrhage was reported in 1.9 per cent of 9609 cases in one series⁴ and is 2.0 per cent of 15,500 cases in another.¹⁵ Instances of gross pericardial hemorrhage and tamponade have been reported.⁹⁻⁷ Wright found some degree of bleeding in 9.0 per cent of his cases. One hundred twenty-two deaths from bleeding were reported by 228 doctors answering a questionnaire on the subject.¹⁶ Rytand, then, is not convinced that anyone should be treated with anticoagulants.

Russek has presented the second viewpoint.¹⁷ He has used generally the following criteria in dividing his patients into two groups: (1) history of previous infarction; (2) intractable pain; (3)

severe or persistent shock; (4) significant cardiac enlargement; (5) gallop rhythm; (6) congestive heart failure; (7) arrhythmias; (8) diabetic acidosis, obesity, or other severe complicating illness. Those patients with one or a combination of these findings he classified as "poor risk". The remainder he considered "good risk". It should be pointed out that these patients were classified in retrospect from the records and that it might be somewhat easier to separate them in this manner than when seen acutely ill in the emergency room. In the "poor risk" group of 220 patients the mortality rate was 44.5 per cent and TEP were observed in 7.7 per cent. In his "good risk" group of 204 patients the mortality rate was only 2.5 per cent. Two of these died within the first 24 hours and one died of ventricular rupture. He believes that only two of these deaths, less than one per cent of his group, were preventable. TEP occurred in less than one per cent also and caused one death. Major hemorrhage is encountered in about two per cent of patients subjected to therapy with anticoagulants and deaths do occur. Apparently, from the above data, the incidence of major complications from the drugs is higher than that from the disease in the "good risk" patients. Therefore Russek feels that only those who fit into his classification of the "poor risk" group should receive anticoagulants.

Wright, pioneer in the use of anticoagulants, is still the most enthusiastic proponent of the routine administration of these drugs.²³ He advocates beginning use of this medication as long as three to four weeks after the acute attack. His position can be stated briefly: (1) His studies are adequately controlled and the treatment has been proven beneficial. (2) One cannot determine in the first 24 hours who is a poor risk. Of 100 of his cases reviewed and considered mild initially by Russek's criteria, 26 per cent had to be reclassified after 24 hours. (3) When re-examined and separated according to Russek's multiple criteria in retrospect, his good risk cases were found to have a mortality rate of less than two per cent in both treated and untreated groups. However, TEP in the untreated cases were still 29 per hundred cases as compared with only nine per hundred in the treated group. (4) At autopsy, mural thrombi were found in about two-thirds of the untreated cases as compared to one-third of the treated cases. Extracardiac TEP averaged 125 per hundred in the untreated and only 45 per hundred in the treated cases. Only 13 per cent

of the TEP were recognized clinically. (5) In answer to the argument that occurrence of subintimal hemorrhage beneath an arteriosclerotic plaque in the coronary arteries would make use of anticoagulants dangerous, he found that about 75 per cent of his original infarctions at autopsy were due to thrombotic occlusions and only three per cent due to subintimal hemorrhage.

Some mention should be made of the manner in which the anticoagulant agents should be used. Although no studies of the effectiveness of Dicumarol alone as compared to combined Dicumarol and Heparin are available, the consensus is that both should be started immediately. Mural thrombi frequently begin to form within a few hours. Since Dicumarol has little effect for 48-72 hours, it seems reasonable to attempt to protect the patient during this period with the almost instantaneous action of Heparin. After the prothrombin time has been brought into therapeutic range with Dicumarol, the Heparin can be discontinued.

Conclusions

After reviewing the statistical studies and the various opinions regarding these studies, the clinician is still faced with the problem of who to treat with anticoagulants. Certainly, no precise indications can be deduced from the information available. In following patients under treatment with these drugs, one is impressed by two things: first, the frequency of occurrence of embolic phenomena while the prothrombin time is within good therapeutic range; second, the incidence of significant hemorrhage when the patient is being followed carefully and is apparently under satisfactory control. One can reasonably conclude only that anticoagulants may favorably affect the mortality and morbidity in certain situations. Probably each patient should be approached as an individual problem. If generalizations must be made it would seem that those most likely to benefit would fall into the following categories: (1) Patients with heart failure. Kerwin found that the reduction in mortality in his treated patients was confined to the group with heart failure. In the cases without heart failure, mortality figures were approximately the same as in the control series. (2) Patients with a history of previous thrombophlebitis and pulmonary infarction, especially those with varicose veins. (3) Patients in whom shock has occurred. And (4) patients with auricular fibrillation. Under any circumstances, these agents are potentially dangerous. The physician using them should be constantly aware of the risk involved in selecting patients and the importance

of following them during treatment.

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Improved Techniques in Hemorrhoidectomies

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THIS PAPER DEALS with the surgical procedure and post-operative care used in 800 cases of internal, interno-external and external hemorrhoids with an overall evaluation of results. All cases were treated on the Surgical Service of the VA Hospital in Dayton, Ohio, and the VA Hospital in Augusta, Georgia. All, with the exception of a small percentage of females, were males ranging in age from 19 to 85 years.

It is the object of this paper to discuss improved surgical techniques and treatment of hemorrhoids with a short discussion of post-operative care chiefly with reference to post-operative discomfort.

No case was taken to surgery for a hemorrhoidectomy without first a complete history and physical and, if indicated, a comprehensive study to rule out colon and rectal pathology. Disease above the anal canal is often undiagnosed and also frequently overlooked. Proof that many rectal and colon lesions are not diagnosed is clearly brought out in a recent paper by Dr. Fansler, entitled "Causes of Error in Proctologic Diagnosis and Treatment."

It has long been felt that improvement in surgical technique is more important in allaying post-operative pain than many other procedures which are commonly done. However, to obtain satisfactory results with any procedure an integration of anatomic, physiologic and pathologic factors must be considered.

As a surgical technique, cautery and injection of hemorrhoids should be frowned on and avoided whenever possible. It is the duty of the surgeon or proctologist to further this opinion. In a few isolated instances, such as advanced age or poor operative risk, cautery or injection may be used. However, it must be borne in mind that

when cautery is employed, it is being used on mucus membrane. Thus the danger of scarring and stricture must be taken into consideration. The post-operative tendency to cicatricial healing within the anal canal merits serious thought. It would seem that cautery should be avoided as often in the anal canal as in the oral cavity.

On the other hand, injection of internal hemorrhoids is a poor technique for an entirely different reason. When the use of sclerosing fluid is used, it produces a hardened vein and subsequently a hardened tubular mass in the anal canal. If two, three or four veins are injected, three or four hardened masses result. These hardened masses are within the contractile portion of the anal sphincters. This is antiphysiologic and decreases the efficiency of sphincter function. In summarizing the subjects of cautery and injection I would discourage their use as a means of obtaining better surgical results in hemorrhoidectomy. With the rejection of cautery and injection in the anal canal a step forward has been achieved.

There are perhaps one hundred different methods of performing hemorrhoidectomy. In spite of all these diverse procedures, post-operative pain remains a vexing problem. Post-operative pain is a greater factor as regards the patient than the final operative result. This alleviation of post-operative pain was constantly in mind when the following types of improved techniques were tried, and observed.

1. *Careful surgical technique.* Many hemorrhoidectomies are approached with carelessness. Many are done poorly because of failure to obtain a dry field, and to maintain proper mucus membrane bridges between excised hemorrhoidal groups.

2. *Removal of hemorrhoid at different levels in anal canal.* It is sometimes possible to remove

hemorrhoidal groups at different levels in the anal canal. If this can be accomplished it is an aid in maintaining elasticity and avoiding stricture. However, there is always a mild to moderate degree of cryptitis and papillitis with all hemorrhoids and crypts should be probed and laid open if infection is present. At times a hemorrhoid when removed will include the papillae and crypt in the immediate vicinity. Examination of the crypts should not be neglected. Removal of hemorrhoids at different levels will help to avoid an annular type constriction that is sometimes felt in the anal canal following hemorrhoidectomy.

3. *Avoidance of wide prolonged retraction of anal sphincters with heavy retractors.* Many surgeons keep the anal canal widely retracted for 30 minutes to an hour. In this manner post-operative sphincter spasm is increased and pain results. Extensive prolonged retraction of sphincter muscles is not necessary. When anesthesia is adequate, gentle digital dilation, close inspection of the anal canal with ligation of hemorrhoids is all that is necessary for removal. After hemorrhoids are noted they can be removed without wide retraction. A series of Allis clamps will bring the entire hemorrhoid into view, including the papillae and crypts in the vicinity. Instruments to force retraction of anal sphincter muscles are not needed and should not be used.

4. *Avoiding "trauma" to anal tissues.* Soft tissues of the anal canal should be handled gently and cut cleanly. Trauma, as is produced by forced retraction or stretching, will result in edema of anal tissues. The presence of edema will promote spasm post-operatively and this is the chief complication we are trying to reduce or avoid. If spasm can be minimized, post-operative discomfort is also minimized.

5. *Allow entire hemorrhoidal bed to remain open.* Hemostasis should be maintained and hemorrhoidal bed edges should be trimmed back to avoid inversion while healing. Drainage is facilitated by allowing hemorrhoidal beds to remain open. Re-epithelialization between mucus membrane bridges is rapid and thus elasticity in canal is not impaired. Expansion post-operatively is not as painful when hemorrhoidal beds are left open, particularly with regard to first bowel movement and digital dilations.

6. *Type of anal packs.* Many types of anal packs are still used in the anal canal after operation. With reference to anal packs, I would like to quote the following statement: "The anus is an oval aperture, longitudinal in repose;" this state-

ment was made by Dr. Hirschman in his text, "Synopsis of Ano-Rectal Diseases." "The anus appears as an anteroposterior slit;" this statement was made by Dr. Bacon in his text "Principles of Proctology." These statements are self evident when examining the anal canal. Anatomically, in repose, the anal canal presents a longitudinal slit and the rectum, in repose and before insufflation, a transverse slit.

However, regardless of these statements and regardless of individual observation of anatomical position of anus and anal canal, rolled packs or plugs continue to be inserted into anal canals post-operatively. These plugs prevent anal sphincters from resuming their normal anatomical position. Thus, by preventing relaxation of sphincters, spasm is produced and there is added post-operative pain and discomfort. A recommended technique is the use of one or two narrow leaves of gauze impregnated with vaseline. This will allow sphincters to relax and assume normal, anatomical position, that is, a longitudinal slit. This technique also allows gas to seep out of the anal canal without discomfort. This small pack will prevent adhesions which might otherwise form during the first 24 hours. The pack will often slide out of the anal canal with first hot sitz bath, usually taken about 24 hours after surgery. An added reason for a small anal pack is that less packing lessens trauma and therefore lessens edema.

7. *Type suture used at base of hemorrhoid.* Lantern slides will be shown at end of this paper to illustrate the type of suture used. It is felt that this type suture is an improved surgical technique because it is an aid in reducing post-operative discomfort. A long doubled suture is placed through the base of the hemorrhoid. The needle is then cut off. This leaves a double strand suture that can be tied at each side of the base of the hemorrhoid. This acts to flatten out the hemorrhoidal stump. If three or four hemorrhoids are removed, there will necessarily be three or four tied sutures at the base of the hemorrhoid. Three or four tubular shaped stumps will then repose in the anal canal. These act as an irritative source and promote sphincter spasm. Spasm may be produced when gas is passed, during the first bowel movement and during digital dilations. The type of suture shown and described acts to flatten out the stump at the hemorrhoidal base. This decreases the size of the irritative source in the anal canal. An added reason for considering this type suture an improvement in technique and an aid in allaying post-operative discomfort is this: when the

mucus membrane in the vicinity of the hemorrhoidal stump is flattened out, it increases the actual circumferential amount of mucus membrane remaining and thus aids elasticity and relaxation within the anal canal. This suture cannot slip, which is a re-assuring factor to the operator.

8. *Psychic approach.* This is not an improved surgical technique but is a factor in controlling post-operative pain. The psychic approach should not be overdone; it should rather be minimized. However, a discussion of post-operative pain with the patient is, I believe, a definite aid in reducing post-operative discomfort in so far as it helps the patient to understand the factors causing pain post-operatively and thus helps him to try and make an adjustment to the pain. A patient judges the result of an anal operation by the smoothness felt at the anal aperture and the amount of pain felt postoperatively. A short explanation pre-operatively with the patient is helpful concerning the following factors: perception of pain and reaction to pain. If the patient has some idea what to expect in post-operative discomfort and pain, he will prepare or adjust himself, so to speak and make a better adjustment to the pain. Some factors that should be included in these discussions are, namely, what is a hemorrhoid—how large is it—how many do I have—what causes the pain—what causes a sphincter spasm—how much spotty bleeding is expected during the healing process, etc.? A discussion of these factors will often break down an erroneous and preconceived pain complex associated with hemorrhoidectomy.

9. *Local Agents as postoperative aids to reducing pain.* I have found that a much greater reduction in postoperative pain has been achieved by putting into practice the enumerated improved surgical techniques than by using any of the numerous local treatments, such as salves, ointments and lotions, or injections of long lasting anesthetic agents. These local agents should be used only as adjunctive treatment to help allay discomfort. A recent local agent that has been especially effective for quick acting local relief is "xylocaine ointment". Injections of long lasting anesthetic agents are not used, first, because it is felt that to be effective the agent must be injected into or under the anal sphincters, and to do this some of the agent will probably reach loose fatty type tissue, such as is present in the ischiorectal space. This type tissue is always a fertile field for infection. Also when this procedure is accomplished one is injecting through a potentially dirty field and

abscess may easily follow. Secondly, the term "long lasting anesthetic agent" is perhaps a misnomer in relation to this subject as it has been scientifically proven that anesthesia with some agents has been produced by actual destruction of soft tissues in the vicinity of the injection. Thus anesthesia is not, in a true sense, the word for the reaction that has taken place.

Summary

The following improved techniques have been discussed with reference to obtaining better results with less postoperative pain in hemorrhoidectomy: (1.) careful surgical techniques; (2.) removal of hemorrhoidal groups at slightly different levels in anal canal; (3.) avoidance of wide prolonged retraction of anal sphincters with heavy retractors; (4.) avoiding "trauma" to anal tissues to avoid edema and spasm; (5.) allowing entire hemorrhoidal bed to remain open; (6.) type of anal pack; (7.) type suture used at base of hemorrhoid; (8.) psychic approach factors; and (9.) local agents as postoperative aids to reducing pain.

It has been found that by closely following and putting into practice the above enumerated improved techniques, postoperative pain has been greatly reduced.

Morphine is now seldom used postoperatively. The average case has been able to get along with three or four hypodermics of 50 mgm. of demerol. These injections are generally used during the first 24 hours and then one or two are needed after the patients first bowel movement, depending on varying degrees of sphincter spasm set up secondary to the anal expansion.

Blood loss in the average hemorrhoidectomy is from 15 to 25 ccs. Many are performed with a loss of less than this amount.

Digital dilation has been accomplished on the third or fourth day after operation with minimal sphincter spasm and pain.

Observance of these techniques, in addition to reducing postoperative pain and discomfort, has helped to achieve a normally functioning anal canal and complete removal of the pathological condition present.

Veterans Administration Center

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Discussion

Edgar Boling, Atlanta: This paper is an excellent presentation of a most practical subject. It is unfortunately true that the more common operations are given less consideration

of details, careless technique, with too often poor results. It is incredible, but true, that in some surgical clinics where the most painstaking techniques are employed for stomach and biliary tract surgery, the clamp and cautery method of hemorrhoidectomy is still performed.

It is quite natural, however, that there will be some difference of opinion as to technique and as it is the function of the discussor to bring out the pros and cons. It is with the consent of my good friend, Dr. Krause, that I take issue with him on certain opinions expressed. That injection treatment of hemorrhoids "should be frowned on and avoided whenever possible", or "relegated only for the advanced age or poor operative risk", I cannot concur. Actually, injection therapy is not a technique of hemorrhoidectomy and therefore a full discussion of its merits is not pertinent in a discussion of technique. However, the issue has been raised by the Essayist, and I must come to the defense of injection therapy as an excellent means of relieving the patient's symptoms; namely, bleeding, backache, rectal discomfort, and even mild protrusions, without subjecting them to surgical hemorrhoidectomy irrespective of the technique employed. It is an accepted method of treatment of uncomplicated internal hemorrhoids, for all patients of all ages, in good health as well as bad. I personally would not submit to surgical excision if I could be relieved adequately with less drastic measures.

I agree heartily with the necessity for demonstrating all

crypts present and performing adequate cryptectomy to allow for good surgical drainage. This point is neglected more by the general surgeon than any procedure they do in ano-rectal surgery, and it leads to a recurrence of the patient's symptoms following operation.

As to the use of local agents as post-operative aids in reducing pain, I am convinced of the value of zylcaine, a five per cent solution of medicaine in oil preparation, which is injected just beneath the skin perianally. The Essayist mentions the danger of infection and abscess, particularly in the ischio-rectal space, which is again described as a most fertile field for infection, but this has not been my observation with the use of this agent in over one thousand cases. However, let me again sound a warning that the use of the new heralded preparation Effocaine is not without danger. It is an aqueous solution whose mode of action is crystallization in the tissues with slow absorption from same. I have experienced two severe sloughs following its use, and observed similar results by others, one case resulting in a recto-vaginal fistula.

One other point in surgical technique which certainly reduces the post-operative discomfort and which I think is quite essential, although the Essayist did not mention it, is the posterior proctotomy, or partial incision of the sphincter. If this is done, it will definitely prevent post-operative sphincter spasm, and will allow the tissues to heal while at rest. I have seen no ill effects following its judicious use.

Vaccine Trials Cancelled

The decision for Georgia not to participate in the polio vaccine trials this year was based solely on technical aspects that developed locally. State health and medical officials definitely approve of the vaccine and have complete faith in its safety.

This statement comes from the office of Dr. T. F. Sellers, director of the Georgia Department of Public Health.

Dr. Sellers also explained that this year's program is not a vaccination campaign as has been conducted in the past with gamma globulin, but it is rather a test to determine if the new vaccine is efficient in protecting children against polio.

It will be of more value to the people of Georgia and the nation to insure that the vaccine be tested only in absolutely valid test areas, where no recent cases of polio have developed, Dr. Sellers said. Another state will use the vaccine.

The vaccine arrived in Atlanta Sunday, April 25. With its arrival came a telegram from Dr. Hart E. Van Riper, medical director of the National Foundation for Infantile Paralysis, stating that full approval had been given the vaccine by an advisory committee set up to examine all aspects of the vaccine and its recent use of children in Pittsburgh, Pennsylvania.

The telegram also noted that the vaccine should not be used in any area where a case of polio had been reported in the previous 14 days. A second

telegram informed health authorities that tests could, however, be begun in school districts where no such cases of polio had been reported.

After the vaccine and the telegrams arrived, and following the disclosure of two polio cases in Fulton County, Dr. Sellers met with an advisory group composed of pediatricians, medical society representatives, epidemiologists, a representative of the National Foundation for Infantile Paralysis, and health commissioners from Fulton, Cobb and DeKalb counties.

In reaching the decision, Dr. Sellers said, the group had to consider the fact that the Fulton-Cobb-DeKalb area is thickly populated and any attempt to make a division of the test area would be difficult.

"I feel Georgia's part in the experiment would be of doubtful value because the polio season had already begun here," he explained. "Some of the second graders who would have received the first vaccine shots could already have been exposed to polio, and if they later developed the disease the results might be misinterpreted and nullify our part of the program."

Dr. Sellers said he hopes that after this year's test the vaccine will be shown to be effective and be available to commercial sources for general use all over the nation.

Poliomyelitis Immunization

William J. Peeples, M.D., Columbus, Ga.

LANDSTEINER DISCOVERED the virus of poliomyelitis in 1909, but medical science has only recently been able to produce an agent to combat poliomyelitis which has the two-fold characteristic of being sufficiently immunologic, as well as safe for human use. The first attempts at immunization of man were made in the early 1930's by Brodie and Kolmer, but these trials were discontinued because the preparations used were unsafe and were not properly antigenic. It was not until 1940 that Lennette and Gordon in their studies showed that more than one immunologic type of poliomyelitis virus existed, though Burnet and McNamara were suspicious of the existence of more than one variety of virus. Firm establishment of two distinct types was made in 1948, by Kessell and Pait, and this was confirmed by Bodian and co-workers in 1949. Both groups soon thereafter reported a third immunologic variety.

Studies of classification of poliomyelitis virus were organized under the Committee on Typing of the National Poliomyelitis Foundation, and on the basis of more than 100 strains of virus examined, concluded that immunologic studies need only be concerned with three types of virus; namely, type one, Brunhilde strains, type two, or Lansing, and type three, the Leon strains.

One of the outstanding studies that helped develop poliomyelitis vaccine as we know it was carried out by Enders et al, in 1949, who found that poliomyelitis virus could be propagated in tissue culture tubes using non-neural tissues. Enders was also able to produce sufficient quantities of virus for study using this type of tissue culture

technique. This work supported a hypothesis that virus may multiply in non-neural tissue and be disseminated thereafter to the central nervous system. Should this be true it was hoped for prevention's sake that an antibody barrier might be thrown up in the blood stream and prevent the spread of the virus to the central nervous system. Bodian and Hortsman in their experiments found virus in the blood stream prior to the onset of paralysis. They also showed that monkeys passively given relatively low levels of antibody at this time could avoid infection when fed a virus that would normally result in paralysis. Hammon added further knowledge that the viremia was a vulnerable spot in attacking the poliomyelitis virus when he used small doses of antibody in the form of gamma globulin to reduce the severity and incidence of poliomyelitis infection.

It should be stated that paralytic poliomyelitis appears to be an accidental occurrence in the course of a systemic infection that is widely experienced. Poliomyelitis infection usually terminates in immunity to the attacking strain rather than resulting in damage to the central nervous system. Sabin, in experiments with mice, showed that unless immunity to poliomyelitis is acquired early in life when concomitant paralysis is less likely to occur, then the risk of paralysis later in life is considerably increased.

Poliomyelitis, then, is no mysterious disease, but is similar to other infectious diseases and will respond to the basic principles of immunology.

Early approaches to immunization against poliomyelitis were carried on without knowledge regarding pathogenesis and immunologic complexity of the disease and before experience with the many strains that possess different pathogenic

From the Department of Public Health, Columbus, Ga.

characteristics accumulated. One drawback to early attempts at immunization was due to the fact that vaccines were prepared from suspensions of central nervous system tissues which we now know may cause an allergic encephalomyelitis. This type vaccine was too dangerous for human use. Other attempts for immunity were made by feeding attenuated live virus that had been propagated in the central nervous system of rodents, but this too was considered unsafe. Twenty humans, however, ingested virus of this type and reportedly had good immunologic response.

The basic prerequisites of a practicable vaccine are simple. First, there must be a rich source of virus, reasonably free of extraneous antigenic material, and second, a method for destroying the pathogenicity of the virus, without destroying its antigenic qualities. A third criterion might be enhancing antigenic activity with some substance after items one and two are satisfied, and particularly if the virus is antigenically inadequate or borderline in effectiveness. This can be done with substances known as adjuvants.

As a fourth requirement, though all three types of virus produce the same clinical entities, infection by one will not produce antibodies that will neutralize other strains. Therefore, to be practicable any vaccine prepared must contain strains of the three types which give the greatest antigenic stimulation. Salk and his coworkers, as well as Milzer et al, have prepared vaccines using the same strains of the three types; that is, the Mahoney strain for type one, the MEF-1 strain for type two, and the Saukett strain for type three. Salk used formaldehyde to destroy pathogenicity, while Milzer accomplished this by ultraviolet irradiation. Both have used an adjuvant of mineral oil employing a technique described by Freund, as well as using an aqueous vaccine with no adjuvants. As a final prerequisite, the vaccine must be able to protect against contact with poliomyelitis virus of different types encountered under natural circumstances. This is necessary, since it may be that strains of poliomyelitis virus occurring in nature may by-pass the blood stream and attack the central nervous system directly, though this is the exception, rather than the rule. This strongly opposed medical opinion up until the last five-six years.

In preparing the vaccine, both Salk and Milzer grew the virus in roller tube cultures using monkey kidney, finely minced and suspended in a fluid

medium free of protein, but satisfactory for supporting viral growth. This fluid contains amino acids, nucleic acids, vitamins and minerals, etc. Human tissues were not used for culture because of the possibility that they might contain other viral contaminants, such as the agent of infectious hepatitis, which could propagate itself in the tissue culture.

Virus is introduced as a seed into roller cultures of minced monkey kidney with nutrient fluid, after four-six days of incubation to allow tissue growth. Seeded tubes are then allowed to incubate four-five days as poliomyelitis virus attaches itself to tissue cells and using the cell as a host, rapidly multiplies. Viral growth was better on kidney tissue than either testis, muscle, or liver, and multiplied faster. After five days, the virus is harvested by siphonage and is then tested for sterility by culture on a battery of media for bacterial contamination. Potency tests are made by injecting virus into tubes containing monkey kidney, nutrient fluid, and monkey serum. Virus not properly potent will be inhibited by the monkey serum. Guinea pigs and rabbits are injected with the cultured virus to further rule out viral contaminants. The virus is then deactivated with 37 per cent formaldehyde, U.S.P., at 1:4000 strength. Tissue culture tests to determine live virus presence are done, and if no live virus remains, the strain culture is pooled with other strains and the batch neutralized with sodium bisulfate. Sterility is retested, and the pooled virus is injected into tissue cultures, and into monkeys, both intracerebrally and intramuscularly to test for live poliomyelitis virus. Mice, guinea pigs and rabbits are also injected intracerebrally to rule out viral contaminants. Adjuvant is then added to the pooled specimen.

Other agencies check on the safety of the vaccine that is being prepared at present for the National Foundation by four biological laboratories on a non-profit basis, and if any find live virus or other contaminants the batch is discarded. These agencies are the four laboratories themselves, the laboratories of the National Institutes of Health and Dr. Salk's laboratory in Pittsburgh.

Vaccines have been given intramuscularly and intradermally (aqueous). Salk found that the intramuscular injection of an emulsified vaccine (adjuvant) gave far better antibody rises in type three than did the aqueous type and could thus be



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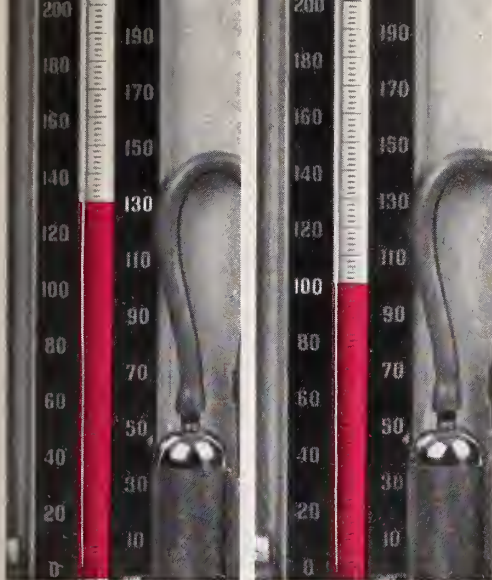
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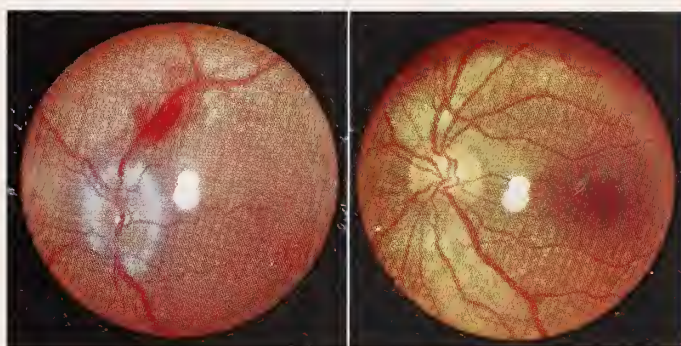
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*THE NORMAL FUNDUS (RIGHT) AS COMPARED WITH THE FUNDUS IN HYPERTENSION SHOWING EDEMA, EXUDATES, AND HEMORRHAGES (LEFT); ILLUSTRATIONS FROM "THE FUNDUS OF THE EYE": BEDELL, A. J.: CIBA CLINICAL SYMPOSIA 4:135 (JULY) 1952. THESE ILLUSTRATIONS ARE FOR DEMONSTRATION PURPOSES ONLY AND DO NOT REPRESENT APRESOLINE-TREATED PATIENTS.

C I B A



ALLEVIATES HAY FEVER, OTHER RESPIRATORY ALLERGIES

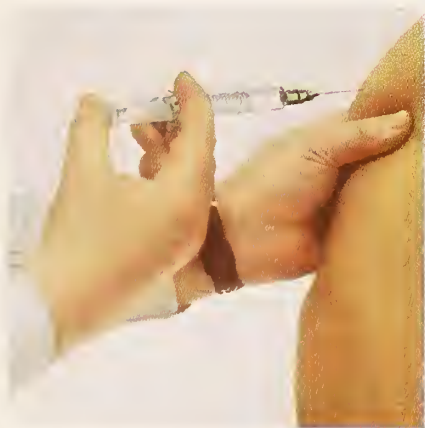
The above photos show a case of allergic rhinitis before and after Pyribenzamine therapy. Many such cases have been reported in the literature. A few examples: Loveless and Dworin¹ found Pyribenzamine beneficial in 82% of 107 patients; Feinberg² noted relief in 82% of 254 cases; Gay and associates³ in 76% of 51 cases; Arbesman and colleagues⁴ in 84% of 106 cases. In a later study Arbesman⁵ rated Pyribenzamine one of "the most effective of all the drugs studied in allergic rhinitis. . . ." *Side effects:* It has been stated that "undesirable symptoms from the use of 50 to 100 mg. doses of Pyribenzamine were rarely of sufficient severity to interfere with its use."⁶ Drowsiness, nausea, epigastric distress, vertigo and other side effects—rarely severe—may occur in some patients.

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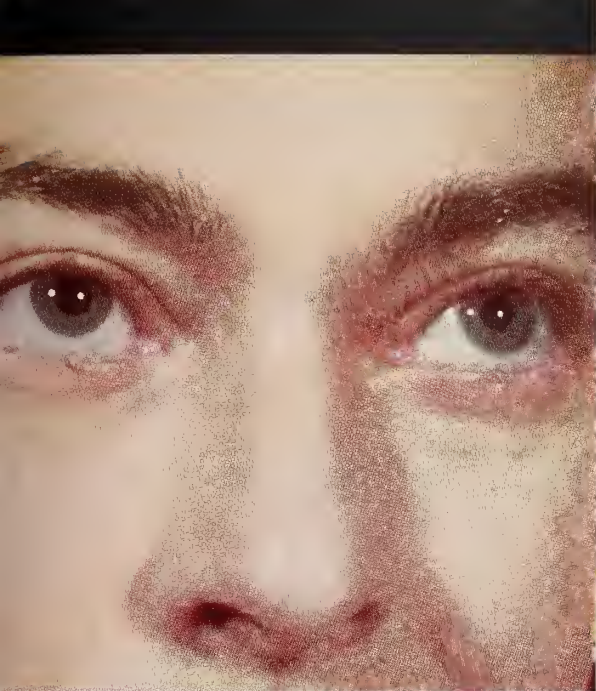
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AGE 75. Arteriosclerotic ulceration with erysipeloid reaction and marked inflammation; after administration of oral Priscoline, 25 mg. three times daily, for one week—increased thereafter to 50 mg. four times daily—there is steady improvement, healing in eight weeks. No other medication used.



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Photographs and accompanying clinical data by courtesy of R. I. Lowenberg, M.D., Consultant in Vascular Surgery, Connecticut State Hospital, Middletown, Connecticut.



AGE 68. Arteriosclerosis obliterans cellulitis; sluggish response to saline dressings and procaine penicillin 300,000 units daily; healing speeded by oral Priscoline, 25 mg. four times daily for one week, 25 mg. every three hours thereafter; healing within six weeks.

attributed to the adjuvant with type three virus. With type one virus, 15 patients showed significant rises in titer after immunization. With type two, 39 patients showed significant rises, and with type three, 15 or 16 patients had significant titer rises. Milzer found essentially the same, except that only 63 per cent of those vaccinated had as much as a four-fold rise in titer for type one, 25 of 30 individuals had four-fold rises for type two, and 27 of 30 had like rises after immunization with type three. Vaccine is given in three doses of one cc. each. Two doses are given one week apart and the final dose is given four weeks after the second.

There were no ill effects recorded from any of the vaccinations performed by either Salk or Milzer on 160 persons. There were neither local, nor systemic reactions. Some erythema was present for 24 hours after giving aqueous vaccine intradermally, but this was gone within 72 hours. Milzer found no antimonkey kidney precipitins in the serum of individuals who developed the highest titers.

Thus from all available published literature, it would seem that an efficient, practicable, safe poliomyelitis vaccine can be produced and administered to humans without harmful effect. It has been demonstrated that the vaccine has good immunologic capacity, and as to its final results only

time can be the judge. It is felt that we are in a comparable stage with poliomyelitis vaccine, to that which we experienced 30 years ago with the toxin-antitoxin vaccine for prophylaxis of diphtheria. Certainly a few years of patience, considerable research, and evaluation will bring forth a satisfactory control for poliomyelitis infection.

Department of Public Health

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Selective Service Announcement

The requirements of the military services for physicians between July 1, 1954 and June 30, 1955, are such that all who have obligations for military service in Priority I and Priority II and that portion of Priority III born after August 30, 1922, will, in all probability, be called to duty.

Due to new processing regulations it will take much longer to issue commissions after applications are filed than in recent months. Therefore,

every effort should be made to have those physicians who will finish internships and residencies by July 1 apply at once for commissions so there will not be a protracted period of waiting between the end of the hospital year and the call to active duty. The only exceptions to the above are those cases of individual physicians who occupy positions that have been declared essential in medical practice in remote communities or those physicians who hold essential positions on medical faculties.

Carcinoma of the Cervix

HOKE WAMMOCK, M.D., Augusta, Ga.

CARCINOMA OF the cervix is accessible for diagnosis and treatment. When diagnostic and therapeutic procedures are properly executed it should be possible to cure these lesions in about 100 per cent of the cases. Despite the availability of diagnostic and therapeutic procedures at our command today too many patients suffer morbidity and mortality from carcinoma of the cervix.

With the advent of cytological study of vaginal smears and the emphasis upon regular pelvic "check-ups", carcinoma of the cervix should be diagnosed in the very early stage of the disease. The cytological or vaginal smear technique is a detection procedure and not a diagnostic exercise, but unfortunately there are too many patients who are treated solely on the basis of a positive vaginal smear. This is a violation of the cardinal principles of cancer therapy. When a vaginal smear is reported by the cytologist as positive it is imperative that this be confirmed by multiple biopsies of the cervix, endocervical and endometrial curettage. Furthermore, it is essential that a proper pelvic examination be made to determine the clinical extent of the disease. Thus, it is necessary to classify clinically the extent of the disease according to the amount of tissue involved locally and distantly. Here again there are too many patients who are treated solely on the microscopic interpretation and without full knowledge of clinical involvement.

When a biopsy is reported in a given case as preinvasive carcinoma it means that the lesion is confined to the natural surfaces of the cervix and that there is no involvement of the stroma. This type of lesion can be treated by conization or cauterization, but it is usually treated by total abdominal hysterectomy. When the biopsy is reported as invasive carcinoma it means that the cancer is invading the stroma and may have

spread to regional lymph nodes. For this type of lesion the choice of treatment today is irradiation therapy; a cycle of x-ray treatments followed by radium. The quality and quantity of irradiation should be cancericidal and without undue injury to normal tissues. Before instituting irradiation therapy the clinical extent of the disease should be classified as to the amount of invaded tissue and the stage of the disease noted according to the League of Nations Classification.

Following irradiation therapy, which takes about six weeks to complete, each individual patient should be re-evaluated with a view toward surgical intervention, namely the performance of a radical hysterectomy. The optimum time for this is approximately two to three months post irradiation. The radical type of hysterectomy will serve to remove hidden and residual cancer before there is an opportunity for the lesion to become reactivated.

There are certain areas in the country where total hysterectomies are performed for Stage I carcinoma of the cervix. This method has not yet been shown to give better results than those obtained with primary irradiation. This procedure should be reserved for a few centers with a large patient load because the hazard is far too great when primary surgery is performed.

The use of combined irradiation therapy and surgery is a procedure designed for the annihilation of cancer and when properly executed will serve to reduce morbidity and mortality. It is urged that a careful evaluation be made of each patient and that the facilities at hand to cope with the problem be given careful consideration before any type of therapy is administered. The results in carcinoma of the cervix can be and should be greatly improved as cancer of the cervix is a curable disease.



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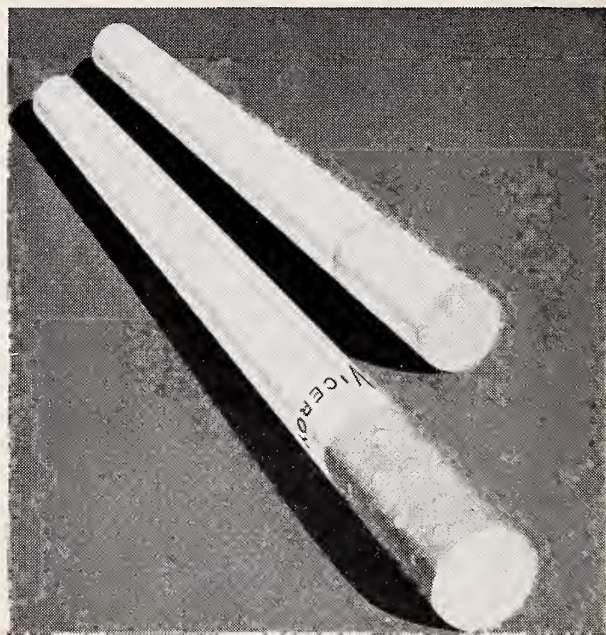


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Treatment of Angina Pectoris

PATIENTS WITH ANGINA may live for many years with their disease as happy and useful citizens. Rigidity in management is ill-advised and a balance must be achieved between excessive activity, the patient's discomfort and his happiness.

When angina pectoris first appears, or suddenly increases in frequency or changes in character, it is likely that a fresh coronary occlusion has occurred; and at such times a period of rest should be prescribed. If time is allowed for re-establishment of collateral coronary circulation, with few demands made upon the heart, a myocardial infarction may occasionally be forestalled. Absolute bed rest is usually unnecessary; combined use of the chair and bed often serves the purpose. Sometimes, one may see a gloomy, anxious patient with pain, confined to rigid bed rest, become much more comfortable when allowed to spend more time sitting in a chair. Some patients with nocturnal angina find that an attack can be quickly aborted simply by sitting up. Most often, the patient sees the doctor some weeks after angina pectoris has appeared. He should be taught to avoid physical or emotional activity that is likely to precipitate an attack.

Weight reduction in the obese patient lessens attacks by reducing cardiac work. Heavy meals may precipitate distress which can be obviated by more frequent, smaller meals. Some persons will show remarkable sensitivity to chilling of minor degree and provision must be made for its control. Limitation or withdrawal of tobacco is important for the occasional patient who has attacks precipitated by smoking, but others are worsened by the frustration of withdrawal. Anemia, hypoglycemia in the insulin treated diabetic, and hyperthyroidism are obvious precipitating factors to be considered. Treatment of congestive heart failure reduces attacks in some patients. Gallstones appear to trouble some through reflex mechanisms, and their removal may be beneficial.

Nitroglycerin is the most reliable drug for relief of angina pectoris. Its action is so prompt and decisive that a therapeutic response is helpful in making diagnosis of angina pectoris. The patient must learn to keep a supply with him constantly. The 1/200 gr. tablet is sufficient for most and can be repeated without concern. Frequently, the physician and the family have an overcautious attitude toward use of the drug, causing the patient to reserve it for severe or prolonged attacks. This attitude should be dispelled and the patient encouraged to use nitroglycerin not only for the mildest attacks, but in anticipation of discomfort. For any activities that may precipitate an attack, the drug should be used. Reassurance should be given that the throbbing headache, often produced by use the first few times, disappears with continued use. Some patients prefer other nitrite preparations, such as amyl nitrite pearls or octyl nitrite inhalers; but, generally, these are less effective than nitroglycerin. Nitranitol ointment is of supplementary value and may prevent some attacks by virtue of its slow absorption when massaged into the skin. The long-acting nitrites may also be useful orally in this manner. Among many medications recommended for reducing frequency and severity of attacks are khellin, testosterone, papaverine, the xanthines and the complex nitrites. Generally, their use is undependable. Peritrate (pentaerythritol tetranitrate), however, may be of value in this regard and its trial is recommended. It is more apt to be effective without producing headache than other long-acting nitrites. Mild sedation with phenobarbital is of well-established value, particularly for the tense individual.

The therapeutic production of hypothyroidism has been helpful in patients with marked incapacity due to angina pectoris. One should consider this in patients with frequent, prolonged bouts of coronary insufficiency or with angina decubitus. Its use has enabled some otherwise com-

pletely incapacitated by pain to return to gainful activity. Radio-active iodine is the only dependable method of fully suppressing the thyroid function. Surgery is ordinarily too hazardous and the anti-thyroid drugs alone are usually less effective. Tapazole, 10 mg. four times daily, or propylthiouracil, 100 mg. four times daily, is worthy of trial, however, when simpler measures have been insufficient.

Recently, there has been much interest in surgical procedures for improving coronary flow, but their use at this time is highly restricted. At present, a low cholesterol diet is an unsettled problem, but the majority of physicians are not too rigid regarding it. The evidence for long-term anti-coagulant therapy does not justify its use at this time.

Health Conference

More than 450 Georgia health workers spent April 12-14 in Savannah taking stock of public health progress and speculating on the health of the world of tomorrow.

The Georgia Public Health Association, whose membership is made up of employees of health departments and agencies, featured several prominent out-of-state speakers as well as Georgia health experts.

The association also unanimously reaffirmed its past endorsement of fluoridation of public water supplies as a safe, economical means of reducing tooth decay by two thirds.

Among new officers named were Dr. J. G. Williams, Atlanta dentist and State Health Board member, as president; Dr. W. D. Lundquist, health commissioner at Statesboro, as president-elect for next year; and Miss Patricia Cannon, nursing director at Chatham county, as vice president.

In the future, public health will move from its present progressive but inadequate "brick and mortar" stage to a position of fully serving all the population, according to the prediction of Dr. J. W. R. Norton, North Carolina's health director and keynote speaker of the convention.

Chronic diseases and the diseases of old age will demand much more attention in the future, since there will be more old people, according to a panel on these diseases led by Dr. John Venable, training director of the Georgia Department of Public Health.

Latest progress in rehabilitation of the physically handicapped was outlined by Dr. Joseph G. Benton of the New York University-Bellevue Medical Center of New York City.

Five Georgia counties — Glynn, Muscogee, Chatham, Richmond and DeKalb, were commended for achievement in integrating public health programs and hospital services during recent

years by Dr. R. C. Williams, director of the Division of Hospital Services of the Georgia Department of Public Health.

Miss Bernice McCullar, director of public relations for the Georgia Department of Public Health, described the ideal public health worker as one who is skilled in human relations, has faith in himself, in other people, and in God.

Home accident prevention was spotlighted during a panel discussion led by Thomas Fansler, of the National Safety Council. Panel member Dr. J. F. Hooker, medical director of Georgia's Southeastern Health Region, pointed out the need for using all community resources, including schools, newspapers, radio and television.

A report on recent legislative and research developments in the U. S. Public Health Service was given by Dr. C. J. Van Slyke of the National Institutes of Health, Bethesda, Maryland. Dr. Van Slyke said the President has made five major recommendations to Congress on health programs, insurance, hospital construction, vocational rehabilitation, and federal aid to states.

Other general officers named were Mrs. Mayola D. Center, health education consultant, of the Georgia Department of Public Health, as secretary; Ernest B. Davis, accounting director of the State Health department, as treasurer; Dr. T. O. Vinson, DeKalb health commissioner and Dr. Ernest Thompson, Walton commissioner, as members-at-large of the board of directors; Dr. M. E. Winchester, health commissioner at Brunswick, as representative on the governing council of the American Public Health Association; and Dr. John E. McCroan, Jr., of the Georgia Health Department's Division of Epidemiology, as representative on the governing council of the Southern Branch of the American Public Health Association.

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physician's bookshelf

A DOCTOR TALKS TO WOMEN—By Samuel Raynor Meaker, M.D., Fellow of the American College of Surgeons—Specialist Certified by the American Board of Obstetrics and Gynecology. 222 pages. "A book for intelligent women who want to learn about the working of their bodies, and in particular of their reproductive organs, in health and in disease." Published by Simon and Schuster, N. Y., 1954. Price \$3.95.

MAYO CLINIC DIET MANUAL—By the Committee on Dietetics of the Mayo Clinic. New, Second Edition. 247 pages. Philadelphia and London: W. B. Saunders Company, 1954. Price \$5.50.

GEORGIA HOSPITAL DIET MANUAL—Prepared with the cooperation of The Medical Association of Georgia, The Georgia Dietetic Association, The Atlanta Dietetic Association and The Georgia Department of Public Health. 108 pages. Requests for copies should be mailed to the Division of Hospital Services, Georgia Dept. of Public Health, Atlanta 3, Georgia. Price (out of state distribution) \$1.00.

NEOMYCIN. Research Division, S. B. Penick & Company, 50 Church Street, New York 8, N. Y. Brochure is a review of pertinent and recent literature dealing with the investigational and clinical aspects of Neomycin therapy. 31 pages.

MANUAL OF CLINICAL MYCOLOGY (2nd Edition)—By Norman F. Conant, Ph.D., Professor of Mycology and Associate Professor of Bacteriology, Duke University School of Medicine; David Tillerson Smith, M.D., Professor of Bacteriology and Associate Professor of Medicine, Duke University School of Medicine; Roger Denio Baker, M.D., Chief Laboratory Service, Veterans Administration Hospital, Durham, N. C., and Professor of Pathology, Duke University School of Medicine; Jasper Lamar Callaway, M.D., Professor of Dermatology and Syphilology, Duke University School of Medicine; Donald Stover Martin, M.D. Chief, Bacteriology Section, Communicable Disease Center, Chamblee, Georgia. 456 pages including index.

CURRENT THERAPY 1954—Latest Approved Methods of Treatment for the Practicing Physician; Editor: Howard F. Conn, M.D.; Consulting Editors: M. Edward Davis, Vincent J. Derbes, Garfield G. Duncan, Hugh J. Jewett, William J. Kerr, Perrin H. Long, H. Houston Merritt, Paul A. O'Leary, Walter L. Palmer, Hobart A. Reimann, Cyrus C. Sturgis, Robert H. Williams. 898 pages. Philadelphia and London, W. B. Saunders Company, 1954. Price \$11.00.



abstracts by georgia authors

Levy, Tracy, M.D., U. S. Public Health Service Hospital, Memphis, Tenn. Pre-employment Examinations of 4,506 Federal Employees. *Ind. Med. and Surg.* 23:55-58 (Feb. 1954).

A critical survey of the pre-employment examinations of 4,506 Federal employee applicants made over a 10-month period (June 1, 1951) through March 31, 1952) is presented. Among these 4,506 examinees, a total of 2,734 medical defects were recorded. Only eight (0.17 per cent), of the entire group of 4,506, were medically unemployable. Two of these had active pulmonary tuberculosis; one had active urinary tract tuberculosis; five had psychoses.

Goodwin, Melvin H. Jr., Communicable Disease Center, 50 Seventh St., N. E., Atlanta. "Observations on the Biology of the Lizard Mite *Geckobiella Texana* (Banks) 1904 (Acarina: Pterygosomidae)" *J. Parasitol.* 40:54-59 (Feb.) 1954.

The biology of a pterygosomid mite, *Geckobiella texana* (Banks) 1904, was studied in connection with investigations of the transmission of a saurian haemogregarine in the fence lizard, *Sceloporus undulatus undulatus* (Latreille). Colonies of mites were maintained on lizards in the laboratory. Larvae, nymphs, and adult male and female mites fed on blood. Oviposition in nature was not observed, but in the laboratory

no preference was shown among the oviposition sites available. Development of the female, from egg to gravid adult, required from 42 to 86 days. The stages recognized and the time of development at temperatures between 22 and 29 degrees C. were as follows: 1. egg, 6 to 8 days; 2. deutovum, 5 to 8 days; 3. larva, 9 to 31 days; 4. nymphochrysalis, 4 to 7 days; 5. nymph, 7 to 15 days; 6. imagochrysalis, 4 to 7 days; 7. adult female, 7 to 10 days for engorgement. The male omitted the nymph and nymphochrysalis stages. The resting stages developed within the integument of the succeeding active stage.

Jourard, Sidney M., Emory. "Ego Strength and the Recall of Tasks," J. Abnorm. & Social Psychol. 49:51-58 (Jan.) 1954.

Psychoanalysts use the term "ego strength" in a manner which renders it synonymous with the more general concept of "mental health". It is generally assumed that the stronger the ego, the lesser will be the likelihood of repression of unpleasant past experiences. The present experiment aimed at testing this hypothesis. Fifty-eight nursing students were tested with thirty assorted tasks under the guise that it was an IQ test. In random order, one half of these tasks were interrupted prior to completion, giving each subject the experience of failure. Subjects then were asked to recall the names of as many of the tasks as they could. Each subject also had taken the Rorschach Ink-Blot test, from which a quantitative index of ego strength was derived. If the Rorschach indices were valid, and if recall preferences reflected the presence or absence of repressive tendencies the Rorschach and recall measures that were derived should have been correlated with each other. Negative results were obtained, thus raising the question of the validity of the findings of other workers in this area.

Juniper, Kerrison Jr., Veterans' Administration Hosp., Atlanta, and Emory University School of Medicine. "Venous 'Spiders' in Chronic Lymphatic Leukemia," Am. J. Med. 16:304-306 (Feb.) 1954.

This report reviewed several types of cutaneous vascular "spiders" of the skin and described venous vascular formations of the skin in a patient with chronic lymphatic leukemia. Illustrations of one of these lesions with biopsy are shown. Although the lesions resembled the arterial spider usually associated with chronic liver disease, they proved to be venous in origin and were thought to be associated with the patient's leukemia rather than a result of liver involvement. These skin lesions appeared to be related to thrombosis of veins, the immediate cause of which was not apparent. Sufficient leukemic cell infiltration in the center of these lesions was not present to suggest a direct causal relationship. Previously described vascular skin lesions in leukemia have been telangiectatic in nature and not true "spiders".

Manchester, P. Thomas, Emory University School of Medicine. "The X-Ray Diagnosis of Orbital Tumors," Sou. Med. J. 47:231-234 (Mar.) 1954.

One of the most difficult diagnostic problems is that of a suspected orbital tumor. Often these tumors are not palpable and yet surgical exploration of the orbit is hazardous. For this condition we are extremely dependent upon the arts of the roentgenologist. Roentgenographic changes which are suggestive of orbital tumor include (1) increased soft tissue density, (2) increased orbital volume, (3) areas of dehiscences and rarefaction, (4) hyperostosis, and (5) enlargement of the optic foramen. New techniques which may be applicable to the suspected cases of orbital tumor include (1) tomography, (2) injection of air or other contrast media into the retrobulbar tissues, (3) cerebral arteriography using rapid serial methods.

McCain, John R., Emory Dept. of Ob. & Gyn., Atlanta. "The Management of Hemorrhage in the Last Half of Pregnancy," J. Sou. Car. 50:45-51 (Feb.) 1954.

The most serious causes of hemorrhage in the last half of pregnancy are placenta previa and abruptio of the placenta. Patients with placenta previa have a high infant mortality rate associated with the prematurity of the infant. Selected

patients may be treated expectantly for placenta previa so that the infant may become more mature before delivery. Before a cesarean section is undertaken for the delivery of a patient with a placenta previa, the diagnosis should be confirmed by a vaginal examination.

An abruptio of the placenta is the most dangerous cause of bleeding in the last half of pregnancy. Preparation should be made to transfuse the patient before, during and after delivery if it should become necessary. After the patient's condition has been stabilized the treatment consists of inducing labor by the rupture of the amniotic membrane for a vaginal delivery.

Rinker, J. Robert, Augusta. "Epididymectomy and Antituberculosis Drugs in the Treatment of Tuberculosis Epididymitis," Sou. Med. J. 47:193-196 (Mar.) 1954.

The surgical specimens (twenty-nine epididymi and one testicle) from twenty-nine patients operated on for tuberculous epididymitis were studied with reference to their pre-operative treatment consisting of various combinations of Streptomycin, P.A.S., and INH. The antituberculosis drugs appear to be relatively ineffective in the epididymis, as in only two specimens did a cure appear to have been effected, and those after long periods of treatment. Other patients with even longer periods of treatment were not cured though clinically quiescent. Early epididymectomy in conjunction with drugs is the treatment of choice. Orchidectomy, although practiced ruthlessly by many, is rarely necessary, as the epididymis can be removed without damage to the blood supply to the testicle, though in tuberculosis it may be technically difficult. Three drawings illustrating technique of epididymectomy.

Motion picture, "Technique of Epididymectomy in Tuberculous Epididymitis," by author, catalogued in Film Library, American Urological Association, 915 Nineteenth Street, N. W., Washington, D. C.

Thigpen, Corbett H. and Cleckley, Hervey, Med. Coll. of Ga., Augusta. "A Case of Multiple Personality," J. Abnorm. & Social Psychol. 49:135-151 (Jan.) 1954.

Eve White, a demure, retiring and very circumspect married woman was treated for headaches and black-outs. An unfinished letter in her familiar handwriting was received. The page contained an irrelevant postscript apparently scrawled by another hand.

During the next interview Mrs. White denied sending a letter. She impulsively put both hands to her head, her face for a moment became blank. As her hands fell back a fresh reckless smile lit the new countenance. An unknown voice, gay and distinctly playful, said: "Hi there, Doc!"

This new girl lacked all of Mrs. White's formality and reserve. Sprightly and carefree, she spoke with an impish air, always referring to the other as *she* or *her*. When asked she gave her own name as Eve Black. Facial expressions, posture, every nuance of gesture, every emotional response, emphasized the separate identity she claimed.

Denying any participation in the other's marriage, any maternal relation to her child, Miss Black discussed her own interests, recounted numerous lively and irresponsible exploits of a party girl.

Though she has free access to Eve White's thoughts and memory she does not participate in the young mother's feelings and attitudes. Eve White has no awareness of what Miss Black experiences and had no suspicion of her existence. Glances unknown to Eve White's quiet eyes sparkle as Miss Black speaks in a language quite foreign to the other. She has caused the capable and conscientious Eve White to lose job after job.

Months later a third personality emerged who calls herself Jane. Unlike the second she claims to have had no past experience, no existence, prior to her sudden appearance during an interview. This new-comer is impressively more than a sum of the other two. Jane knows what both Eves do and think but can emerge only through Mrs. White. In her there is promise of a maturity and capability, a capacity for life, beyond the range of either Eve.

Rorschach studies of these two personalities, electroencephalographic studies during the manifestation of each personality and handwriting analysis by an expert are presented.

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By G. Lombard Kelly, A.B., B.S.Med., M.D. Specialist in Disorders of Sexual Function. (President Emeritus and formerly Professor of Anatomy, Medical College of Georgia.)

With a foreword by

Robert B. Greenblatt, B.A., M.D., Professor of Endocrinology in the Medical College of Georgia.

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doctor placement page

AVAILABLE PHYSICIANS

Batchelor, Marvin, R., M.D., General Hospital, Knoxville, Tenn., age 33, priority 4, married, Methodist, desires general practice in community of 5,000 to 25,000 with well equipped hospital, in Georgia. Graduated University of Tennessee, 1950. Will consider group and industrial practice, Available March, 1954.

Bates, Phillips L., M.D., Quarters "L," U.S. Naval Hospital, Camp LeJeune, N. C., age 35, resigning to inactive reserves, married, Presbyterian, specialty—Urology, desires clinic or as an assistant or associate in community of 30,000 in Georgia, graduate University of Rochester, 1946.

Dwight, J. Brown, M.D., Capt. USAF (MC) 3320th Medical Group, Amarillo AFB, Texas, age 28, at present a physician in the Armed Forces to be released from active duty in January, married, Protestant, graduate Bowman Gray School of Medicine, 1946, completed residency in OB-GYN at the University of Virginia, specialty—Obstetrics and Gynecology.

Dodd, Patricia, M.D. (See Dr. Robert S. McDuffie), age 33, married, desires surgery in community as individual, group or an associate, graduate University of Maryland Medical School, 1944, available April 1, 1954.

Douglas, John J., M.D., 726 14th Ave., Monroe, Wisc., age 38, married, Protestant, desires radiology or an association with doctor in Georgia, graduate University of Rochester School of Medicine.

Gianoullis, James T., M.D., 611 West Grace Street, Richmond 20, Va., age 38, priority 4, married, desires general surgery and gynecology with established surgeon, group or hospital in Georgia, graduate Medical College of Virginia, 1941, six years surgical residency at Medical College of Virginia Hospitals, now available.

Hall, Irving E., Jr., M.D., 8301 16th Street, Silver Springs, Md., age 29, married, Protestant, graduate Cornell University Medical College, 1950, residency at Children's Hospital of D. C., pediatrics, priority 4, interested in pediatrics in Georgia, prefers community of 10,000 to 50,000, available July, 1954.

Hallstrand, David E., M.D., 5 Geisinger Court, Danville, Pa., age 34, priority 4, married, Methodist, desires general surgery in clinic or as an assistant or associate, in Georgia. Graduate Emory University School of Medicine, 1945, graduate University of Pennsylvania School of Medicine, 1950, in surgery, residency at Geisinger Memorial Hospital and Foss Clinic, available July 1, 1954.

Hendrix, Paul C., M.D., 160 South Church Street, Wytheville, Va., served two years in Army with overseas duty, graduate Emory University School of Medicine, 1947, licensed to practice in Georgia, completed 12 months internship and 15 months medical residency at City Hospital, Winston-Salem, N. C., desires general practice in Georgia. Available now.

Hunter, I. H., 204 East Hill Avenue, Valdosta, Ga., age 72, married, Missionary Baptist, graduate Grant University, Tennessee, 1903, specialty pediatrics, prefers community of 1,000, will accept good position with clinic, available April 1, 1954, been in active practice for 50 years.

Johnston, J. Howard, M.D., 107 Dauntless Lane, Hartford, Conn., age 36, married, two children, graduate Dartmouth College, 1939, A.B. degree, Long Island College of Medicine, 1943, M.D. degree.

Kaley, J. S., M.D., 887 Myrtle Street, N. E., Atlanta, Ga., age 33, graduate Vanderbilt University, 1946, interested in general surgery in Georgia.

Leigh, Cortland D., M.D., Route No. 1, Box 337, Odessa, Fla., age 38, married, Presbyterian, graduate University of Pittsburgh School of Medicine, 1940, residency in general surgery at St. Luke's Hospital, New York City, and in thoracic surgery at Seton Hospital, in private surgical practice from 1951 to 1953, desires community in need of surgeon or an associate, now available.

Lippett, Devereux, M.D., 125 Elfretch Alley, Philadelphia, Pa., age 29, married, Episcopal, graduate Harvard Medical School, 1947, desires community in Georgia in clinic or as an assistant or associate in pathology and clinical pathology, available July, 1954.

Lipscomb, James W., M.D., 221-C Georgia Tech-Lawson Apartments, Chamblee, Ga., graduate University of Virginia School of Medicine, 1952, residency in internal medicine at the VA Hospital in Atlanta, will be completed by July 1, 1954, desires internal medicine, will consider general practice in community in Georgia, willing to start new practice or to associate in practice already established.

Lyles, William Sloan, M.D., 12 B College Village, Winston-Salem, N. C., age 30, married, Episcopal, graduate Medical College of South Carolina, 1947, 4½ years general surgery, specialty—general surgery, board qualified, prefers private practice, desires community of 5,000 to 60,000, available July 1, 1954.

May, Robert M., M.D., 1908 Rosemary Hills Drive, Apartment 1, Silver Springs, Md., born Hamburg, Germany, citizen U. S., married, Hebrew, graduate Louisiana State School of Medicine, 1948, residency at Touro Infirmary, Louisiana, priority 4, specialty Ob-Gyn only, desires community in Georgia, available anytime.

McDuffie, Robert S., M.D., U.S. Naval Hospital, Quarters No. 1219, Quantico, Va., age 34, married, in Navy as reserve medical officer, graduate Emory University School of Medicine, 1944, desires location where he and wife can practice as individual, group or associate, limited to Ob-Gyn, available April 1, 1954. (See Dr. Patricia Dodd).

Merchant, John P., Jr., M.D., P. O. Box 1017, South Miami, Fla., age 28, single, Baptist, graduate Medical College of Alabama, 1952, interested in general practice, prefers community in Georgia, available July 1, 1954.

Mitchell, Helen Krysa, M.D., 25 East Washington Street, Chicago 2, Ill., age 37, married, Catholic, graduate University of Illinois, 1943, residency in dermatology at University of Chicago, specialty—dermatology or public health, desires community of 50,000 in Georgia, available three to six months notice.

Mozola, Emil W., M.D., 2624 Noble Road, Cleveland Heights 21, Ohio, age 38, married, Catholic, graduate Hahnemann Medical College and Hospital, 1943, priority 4, would like progressive community in Georgia, had considerable experience in orthopedic, urological, gynecological and traumatic, as well as general surgery, interested in private practice where could do fair amount of general work and of major surgery.

Mundy, Charles B., M.D., Dahlgreen, Va., born New York City, married, Protestant, graduate New York University School of Medicine, 1950, in active duty with U. S. Navy, desires to practice in community of less than 4,000 in Georgia, as general practitioner, available as soon as notified.

Olley, James Francis, M.D., Crawford W. Long Hospital, Atlanta, Ga., age 32, married, Protestant, graduate Jefferson Medical College of Philadelphia, 1945, military service fulfilled, specialty—pathologic anatomy and clinical pathology, clinic or hospital preferred, available July 1, 1954.

Paddock, Robert L., M.D., St. Luke's Methodist Hospital, Cedar Rapids, Iowa, interested in obtaining a location in Georgia suitable for a partnership with Dr. W. D. Regester, available July 1, 1954, general practice, graduate of College of Medical Evangelists in Los Angeles, Calif.

Pittard, M. D., M.D., 1945 Wilford Drive, Brookhaven, Ga., age 27, married, Methodist, graduate Emory University School of Medicine, 1950, at present in the Navy, will be discharged in August, 1954, interested in general practice, clinic, available September 15, 1954.

Porter, Gordon, M.D., 29 Rosebery Place, St. Thomas Ontario, Canada, age 55, married, Canadian, Baptist, graduate Queens University, 1921, residency Chief of Staff—Chief of Surgical Staff, Memorial Hospital, St. Thomas, Ontario, specialty—anesthesia, size of community unimportant, prefers industrial or institutional, now available.

Ranson, Robert F., Captain, MC, Laboratory Service, Rodriguez Army Hospital, Fort Brooke, Puerto Rico, at present in armed forces, graduate University of Oklahoma School of Medicine, 1947, residency in Pathology at same hospital, residency in pathology at Charity Hospital in New Orleans, at Brooke Army Hospital, Sam Houston, Texas, available within six months.

Regester, W. D., M.D., St. Luke's Methodist Hospital, Cedar Rapids, Iowa, interested in obtaining a location suitable for a partnership with Dr. R. L. Paddock, available July 1, 1954, general practice, graduate of College of Medical Evangelists in Los Angeles, Calif.

Rummel, William David, M.D., 1680 Northwest Boulevard, Columbus, Ohio, age 28, married, graduate Hahnemann Medical College of Philadelphia, 1948, served as general resident at Westmoreland Hospital, Pennsylvania, began ophthalmology residency at Ohio State University in March, 1952, Diplomate of the National Board, desires position as an associate with a Diplomate of the American Board of Ophthalmology, available July, 1954.

Sharpe, Joseph H., M.D., Roswell Park Memorial Hospital, Buffalo, N. Y., born Checotah, Okla., single, Episcopal, graduate University of Oklahoma, 1947, residency at VA Hospital, New Mexico, General Hospital, New York, reserves USN, specialty general surgery, desires community in Georgia, available August 1, 1954.

Sigman, Cheney C., M.D., 1962 Johnson Ferry Road, Apartment 1, Chamblee, Ga., age 26, married, priority 4, Lutheran, specialty—pediatrics, graduate Emory University School of Medicine, 1952, pediatric residency will be completed in July, available July 1, 1954.

Sturman, Herman G., M.D., 2700 West 15th Place, Chicago 8, Ill., age 27, married, Jewish, graduate University of Illinois, 1950, residency Mt. Sinai, Chicago and Cook County Hospital, Chicago, priority 4, specialty—Ob-Gyn, prefers community in Georgia, desires Ob-Gyn as assistant or associate or clinic, available June, 1954.

Todd, B. Harris, M.D., Philadelphia General Hospital, Blockely Division, 34th Street and Currier Avenue, Philadelphia, Pa., age 30, married, priority 4, graduate Medical College of South Carolina, 1951.

residency in medicine to be completed in June, 1954, at Philadelphia Hospital, prefers general practice in small community, available June, 1954.

Ullmann, Karl H., M.D., 301 Queens Road, Charlotte, N. C., graduate University of Munich School in 1949, is now chief resident in surgery at St. Joseph's Hospital and staff physician at Southwest Tuberculosis Hospital, Tampa, Fla.

Wachtel, Andrew S., M.D., The Hospital U.S. Soldiers' Home, Washington 25, D. C., age 29, married, Baptist, on military duty in Army, graduate Baylor University School of Medicine, 1950, presently completing military tour, desires community in Georgia, industrial or as assistant or associate, available July 1, 1954.

Wornas, Christian G., M.D., 4504 Pine Street, Apartment 107-A, Philadelphia, Pa., age 30, married, Protestant, graduate Marquette University School of Medicine, 1946, specialty—internal medicine, desires community in Georgia, available June, 1954.

Ambery, Sebastian, 613 Blondeau Street, Eokuk, Iowa, age 43, American, married, Protestant, graduate University of Zurich, Switzerland, 1937, residency, Glenwood, specialty—proctology, priority 3, interested in general practice in community in Georgia.

Beckel, Frank, M.D., Univ. of Pittsburgh School of Medicine, Department of Pathology, Pittsburgh 13, Pennsylvania, age 35, married, graduate Duke University (pathology), priority 4, desires community in Georgia, available July-September 1954.

Cain, Robert T., M.D., 236 Clem Road, Sam Houston Village, San Antonio 9, Texas, age 30, married, one child, Protestant, graduate Emory University School of Medicine, 1953, at present taking rotating internship, prefers community with hospital facilities in Georgia or a clinic, desires to go in with another man if possible—as associate with another younger man or as assistant on temporary basis, available July 15, 1954.

Albea, John M., M.D., Apt. 108, E. Wherry, Fort Campbell, Kentucky, age 29, married, Protestant, graduate Tulane Medical School, 1952, presently an Army Medical Officer, interested in general practice in Georgia, available August 1, 1954.

Berry, Reginald V., M.D., US Naval Hospital, Pensacola, Florida, age 47, married, Protestant, graduate Yale Medical School, 1932, residency Duke University, North Carolina; U. S. Naval Medical Center, Maryland, interested in psychiatry and neurology in Georgia (clinic, assistant associate or institutional), available July-August 1954.

Bogges, Neil D., Jr., M.D., Greenville, General Hospital, Greenville, South Carolina, age 27, married, Methodist, graduate Emory University School of Medicine, 1953, licensed in Georgia, veteran, interested in general practice in Georgia, available July 1, 1954.

Burleson, Robert J., M.D., 1442 Fourth Avenue, SW, Rochester, Minnesota, age 35, married, Christian Church, graduate University of Louisville, 1943, completing 3½ years orthopedic fellowship, Mayo Foundation, priority 4, interested in orthopedic surgery in Georgia, as an assistant or associate, available October 1, 1954.

Cole, Kenneth M., Jr. M.D., 1501 Harlandale Avenue, Dallas 16, Texas, age 30, married, Presbyterian, graduate John Hopkins University School of Medicine, 1951, residency Jefferson Davis Hospital, Texas, one year surgery residency, pres-

ently in practice, wishes to relocate due to inadequate income, exempt from military service, interested in general practice in Georgia, in community of any size, available May 1, 1954.

Coleman, Julian B., M.D., US Naval Air Facility, Weeksville, Elizabeth City, North Carolina, age 33, single, Protestant, graduate McGill University, 1952, priority 4, size of community not important, in clinic or as an assistant or associate, available July 15, 1954.

Dickes, Richard E., M.D., Saginaw General Hospital, Saginaw, Michigan, graduated from University of Michigan Medical School, 1953, intern at Saginaw General Hospital, interested in practicing in Georgia.

DuBose, Bolling S., Jr., M.D., 617 West Pine Street, Johnson City, Pennsylvania, age 30, married, 3 children, Presbyterian, graduate Bowman Gray School of Medicine, 1946, board eligible—internal medicine, presently in practice, wishes to relocate and enter private practice, specialty—internal medicine, desires location in Georgia, available June 1954.

Fitz, Thomas E., M.D., 1053 Oakland Avenue, Rock Hill, South Carolina, age 32, married, 3 children, Presbyterian, graduate Duke University School of Medicine, 1949, specialty—internal medicine and cardiology presently in practice, wishes to relocate due to economic status, desires group or associate practice, available two or three weeks after location secured.

Glassman, Dan, M.D., 400½ Main Street, Point Pleasant, West Virginia, age 43, married, Jewish, exempt, graduate Rush Medical College, 1935, residency at St. Francis Hospital, Charleston, interested in general practice in Georgia, available summer or fall of 1954.

Hunter, Robert, M.D., Hartford Hospital, Hartford, Connecticut, age 32, married, Episcopal, graduate Columbia University College of Physicians and Surgeons, 1943, board eligible—ob-gyn, prefers small clinic or an association, available July 1, 1954.

Lamb, James W., M.D., 906 Monroe Street, Vicksburg, Mississippi, age 38, married, Baptist, graduate Tulane University School of Medicine, 1938, residency Kansas City General Hospital, 4 year fellowship in general surgery, priority 4, specialty—general surgery, available July 1, 1954.

Maxwell, George A., M.D., 818 Thayer Avenue, Silver Springs, Maryland, age 32, married, Presbyterian, graduate University of Maryland Medical School, 1944, residency Maryland General and St. Agnes Hospitals, passed Part I, American Board of Ob-Gyn, wishes to locate in a relatively small town where sailing is readily available, prefers associate, available anytime.

McFarland, Wesley L., M.D., Mid State Baptist Hospital, 2000 Church Street, Nashville, Tennessee, age 29, married, Baptist, graduate Tulane University School of Medicine, 1953, priority 4, interested in general practice in community in Georgia, clinic acceptable, available July 1, 1954.

MacKavanagh, James L., M.D., 160 Marion Avenue, Marrick, L. I., New York, age 44, married, Roman Catholic, graduate Georgetown University Medical School, 1934, presently in general practice, wishes to relocate, priority 3, interested in general practice in Georgia, size of community not too important, available within two or three months after location is selected.

Moseley, Arthur J., M.D., Apt. 1D Woodland Terrace, Columbia, South Caro-

lina, age 29, married, graduate Emory University School of Medicine, 1947, board qualified in internal medicine, recently released from active military duty, residency at Grady Memorial Hospital in internal medicine, available June 1, 1954.

Retterbush, William C., M.D., Knoxville General Hospital, Knoxville, Tennessee, age 30, married, Catholic, graduate Ohio State University, 1947, priority 1-C Disc., interested in general surgery in Georgia, part time industrial to supplement private practice, available September 1, 1954.

Scruggs, W. H., M.D., Bryson City, North Carolina, age 65, married, Baptist, graduate University of Maryland, 1913, prefers small town with hospital facilities, limited general practice, licensed in Georgia, home town in Waycross, Georgia, 1 year in TB work, 3 years in general surgery, available anytime during the next three months.

Spriggs, John B., M.D., 1208 West 6th Street, Silver City, New Mexico, age 39, married, graduate University of Michigan, 1941, residency US Marine Hospital, Maryland, specialty—surgery, presently in practice, wishes to relocate due to economic situation of area, priority 4, desires community in Georgia, available June 1, 1954.

Taber, Richard P., M.D., Department of Pediatrics, University Hospital, Ann Arbor, Michigan, age 30, single, Presbyterian, graduate University of Rochester Medical School, 1948, residency Buffalo Children's Hospital, N. Y.; University Hospital, Michigan, priority 4, interested in pediatrics in Georgia, available July 1, 1954.

Allen, Raymond A., M.D., c/o Mayo Foundation, Rochester, Minn. Born November 6, 1921, Lyman, Utah, single, Mormon, graduate University of Louisville, 1946, assistant resident in pathology one year, New York City Hospital, Fellow in pathology three years, Mayo Foundation, interested in location in Georgia, available July, 1955.

Battle, William C., 1st Lt., USAF (MC), 6407th USAF Hospital, Peamcom Air Base, APO 323, c/o Postmaster, San Francisco, Calif. Graduate Duke Medical School, 1949, surgical internship at Duke 1949-50, Pediatric internship at Long Island College Hospital, 1951-52, Board eligible in pediatrics, plan to take exams this year, currently completing a tour as pediatrician at the 6407th USAF Hospital, Tachikawa, Japan. Available July, 1954.

Bragg, Rudolph, M.D., 567th Medical Squadron, McChord Air Force Base, Washington. Age 28, single, Methodist, graduate Medical College of Georgia, 1952, license held in Georgia, interested in general practice as an individual or associate, in community under 10,000 in Georgia. Available July 1, 1954.

Ganl, Jack H., M.D., Lafayette Charity Hospital, Lafayette, La., age 31, single, Episcopalian, graduate Louisiana State University Medical School, 1952, rotating residency, Lafayette Charity Hospital, interested in general practice, in clinic or as an associate, available July 15, 1954.

Garner, J. W., M.D., Crawfordville, Ga., currently engaged in general practice, age 26, married, one child, Baptist, graduate Medical College of Georgia, 1949, 1½ years general practice residency, Charity Hospital 2A Classification, interested in general practice in Georgia, 2,000 up.

Gray, Henry T., M.D., 9-C Copeley Hill, Charlottesville, Va.; will complete residency in dermatology and syphilology in June of this year, will be Board eligible, most interested in an association with another dermatologist or a group, would not be opposed to solo practice.



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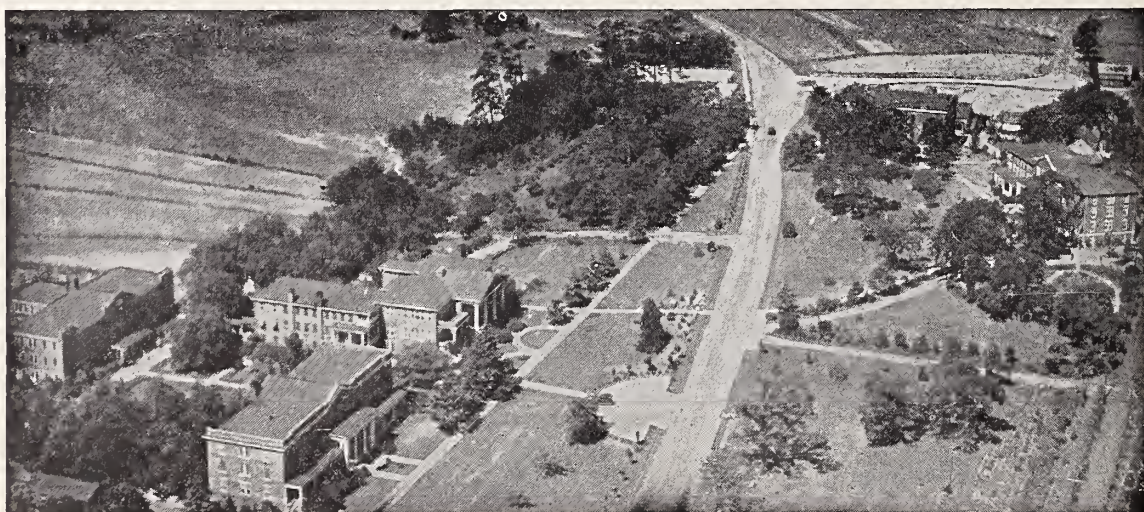
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Kinzer, Gilbert M., Lt. MC USN, Main Dispensary, USNAS, Corpus Christi, Tex., 30 years of age, B.A. degree Vanderbilt University, M.D. degree University of Tennessee, 1947, have a basic science certificate and medical license, owned and operated a small hospital in Caraway, Ark. (GP-Surgery) took PG course in pediatrics at Harvard Postgraduate Medical School, called to active duty '51, graduated from School of Aviation Medicine, which gives special training in EENT, cardiology and physiology, desires to locate in South in a town with minimum 3,000 population, town must have hospital, plans to do general practice with obstetrics and limited major surgery, prefers an association with another doctor.

Moore, Melvin, M.D., 915 East 17th Street, Brooklyn, N. Y. Born January 5, 1924, married, Hebrew, graduate Chicago Medical School, 1946, certified by American Board of Radiology, residency, Newark Beth Israel Hospital, Queens General Hospital, specialty, Radiology, available March, 1954.

Lee, James Earl, M.D., Flower and 5th Avenue Hospital, Interns' Quarters, New York 29, N. Y., age 33, married, Protestant, graduate New York Medical College, 1954, draft exempt by previous service, interested in general practice in Georgia, available July, 1955.

Moseley, Robert W., M.D., 97th General Hospital, APO 757, c/o Postmaster, New York, N. Y., age 28, married, Christian, graduate Medical College of Virginia, 1948, residency Walter Reed Army Hospital, Board eligible for pediatrics. Available July 1, 1954.

Pattison, John D., M.D., FASRON 104 Det. 1, FPO, New York, N. Y., age 34, married, Protestant, graduate University of Pittsburgh, 1944, residency VA Hospital, service completed October 5, 1954, specialty internal medicine, clinic or group practice in Georgia, available one or two months after discharge.

Rutledge, James W., M.D., The John Gaston Hospital, Memphis, Tenn., age 29, married, Protestant, graduate New York Medical College, FFAH 1953, priority 4, served 30 months in USAAF, completing rotating internship at University of Tennessee, interested in general practice in Georgia, available July, 1954.

Sakol, Marvin J., M.D., 233 Ridgedale, Louisville, Ky., interested in internal medicine and hematology, completes residency in internal medicine in July and is particularly well trained in hematology.

Schiffett, Joseph Ray, M.D., US Naval Hospital, Jacksonville, Fla., age 29, married, one child, Protestant, graduate Baylor University College of Medicine, 1953, priority 4, interested in general practice in Georgia, available August 1, 1954.

Segal, Milton, M.D., 675 Dickson Parkway, Mansfield, Ohio, 34 years of age, certified radiologist, interested in practice of radiology in office, hospital or group.

Shea, Wm. H. H., M.D., 568th USAF Dispensary, McGuire Air Force Base, Trenton, N. J., age 33, married, Roman Catholic, graduate University of Maryland, 1951, priority 4, interested in general practice, available July 15, 1954.

Stark, C. V., M.D., Box 109, Arcadia, Fla., wants practice in Georgia during spring of the year only, as he spends winters in Florida, born November 25, 1878, widower, graduate Oploma Medical University, Tenn., 1900, specialty—general medicine, population 1,000 or more.

McCree, Robert L., M.D., 504 Arey Ave., Albemarle, N. C., graduate of Meharry Medical College, 1946, two years residency—internal medicine, finished 3-year term in Army, since discharge have

taken over practice of a classmate, who will return in August, 1954. Desires to establish himself in practice. Would like town with fairly large Negro population.

AVAILABLE LOCATIONS

Abbeville, South Carolina—Needs general surgeon, two general practitioners, 50 bed hospital, good facilities. Office space available. Housing, schools good. (pop. 5,000). Contact: Mr. Sam A. McAvan, Chairman of Board, Abbeville County Memorial Hospital, Abbeville, South Carolina.

Apalachicola, Florida—Small, well operated county hospital. New modern doctors building for rent, which is well equipped. Doctor-surgeon desired. Contact: G. Cecil Gibbs, Chamber of Commerce, Apalachicola, Florida.

Arlington, Georgia—(Calhoun County) In need of surgeon for practice in the new Terrell County Hospital (28 beds). Contact: Mr. W. B. Bostwick, Arlington City Hospital, Arlington, Georgia. (pop. 1,382).

Attapulgus, Georgia—(Decatur County) Present doctor unable to practice on a full scale, and would like to have another physician to keep up the work. Has clinic with waiting rooms for white and colored patients, x-ray, cardiogram, metabolism, pneumothorax, violet ray, and laboratory equipment. Town is centrally located with access to hospitals. Will reserve working space in the clinic, and will sell outright or lease the clinic at very nominal figure. Will cooperate and assist any doctor coming to this town. (pop. 500) (county pop. 22,234) Attapulgus, Georgia.

Austell, Georgia—(Cobb County) Excellently equipped 16 bed hospital with first rate facilities in nearby Marietta and Atlanta. Contact: Dr. J. G. Bussey, Austell Hospital, Austell, Georgia. (pop. 1,230).

Bainbridge, Georgia—(Decatur County) Office furnished and available now. Need general practitioner. Contact: Dr. Henry A. Bridges, 402 S. West Street, Bainbridge, Georgia. (pop. 7,562).

Broxton, Georgia—(Coffee County) Doctors clinic available, also home. 60 room county hospital at Douglas. 7 room doctors building. Contact: Mr. L. L. Denton, Sr., P. O. Box 198, Broxton, Georgia. (pop. 890).

Cairo, Georgia—(Grady County) Grady County Hospital at Cairo, 31 beds. Suitable office facilities with exam room, etc., available reasonably. Houses available for purchase or rent. Needs two physicians. Contact: Mr. Louis A. Powell, P. O. Drawer 387, Cairo, Georgia. (pop. 9,500).

Clarkston, Georgia—(DeKalb County) Needs general practitioner. Offices available rent free. Contact: Mrs. M. E. Flowers, Clarkston, Georgia. (pop. 1,165).

Conyers, Georgia—(Rockdale County) Hospital clinic now in process of being built between Conyers and Millstead. Office space can be rented reasonably. Houses can be rented or bought. Contact: Mr. O. J. Bradford, Conyers, Georgia. (pop. 2,004).

Crawford, Georgia—(Oglethorpe County) Two hospitals in Athens. Office space available for rent. Housing can be arranged satisfactorily. Contact: Mr. C. A. Townes, Crawford, Georgia. (pop. 10,000).

Dawsonville, Georgia—(Dawson County) Have a modern well equipped health clinic. Arrangements for an office can be made without difficulty. No physician in county. (pop. 500) Contact: Mr. Carlton Gilleland, Mayor City of Dawsonville, Dawsonville, Georgia.

Douglas, Georgia—(Coffee County) New Hill-Burton Hospital (65 Beds) Office

space available for rent. Housing can be arranged. Need pediatrician, surgeon, diagnostician. Contact: Dr. T. H. Clark, Douglas, Georgia. (pop. 10,000).

Hampton, Georgia—(Henry County) Hospital in Griffin. Office space, housing available. Contact: Mr. A. L. Cain, Cain's Pharmacy, Hampton, Georgia. (pop. 1,000).

Hawkinsville, Georgia—(Pulaski County) Has a 40-bed hospital. Two suites being built for doctors office. Contact: Mr. W. N. Pate, Chairman, Taylor Memorial Hospital, Hawkinsville, Georgia. (pop. 3,342).

Homerville, Georgia—(Clinch County) Offices available without charge. Private hospital. Contact: Mr. E. K. Avriett, Homerville, Georgia. (pop. 1,787).

Lakeland, Georgia—(Lanier County) One hospital in County. Plenty of office space. Housing is available. Doctors to take over operation of new hospital. Contact: Mr. J. B. Powell, Lakeland, Georgia. (pop. 1,502).

Leesburg, Georgia—(Lee County) Office space available, free. Houses for rent reasonable. Home large enough for office. No physician in county. Contact: W. F. Faircloth, Ph.G., Leesburg, Georgia.

Logansville, Georgia—(Walton County) Legion completing a doctors building. Six room houses available. Contact: Dr. Chas. S. Floyd, Logansville, Georgia. (pop. 700).

Lumber City, Georgia—(Telfair County) Nice brick office building. New hospital in same county. Five room and bath office, rent free for two years. Contact: Mr. T. D. Wooten, Wooten Drug Company, Lumber City, Georgia. (pop. 2,500).

Meigs, Georgia—(Thomas County) Available clinic with all facilities. (pop. 927) Contact: Dr. J. N. Isler, Meigs, Georgia.

Midville, Georgia—(Burke County) Has an 8 room clinic. Nice 3 bedroom home. Clear from \$15,000 to \$20,000 annually. Contact: Mr. J. Rife English, Midville, Georgia. (pop. 682).

Newnan, Georgia—(Coweta County) Excellent opportunity for Negro physician. All hospital facilities and privileges granted by white doctors. Modern housing, good schools, churches. Contact: Dr. G. P. Kinnard, Newnan, Georgia. (pop. 8,218).

Newton, Georgia—(Baker County) Hospital in Camilla, 9 miles away. Can rent or purchase an office. Apartments for rent. Contact: Mr. R. F. Mulford, Newton, Georgia. (pop. 503).

Pearson, Georgia—(Atkinson County) Will furnish house, and equip clinic. New Hill-Burton Hospital at Douglas (15 miles) guarantees staff privileges to GP. Office will be rent free for six months. Contact: Mr. Barney Kraft, Pearson, Georgia. (pop. 1,402).

Smithville, Georgia—(Lee County) Home in Leesburg, office downtown. Completely equipped office of 2 rooms and connecting lavatory and toilet with outlets for sterilizers, etc., attached. All private practice available. Contact: Mr. Chas. A. Dean, Smithville Drug Store, Smithville, Georgia. (pop. 700).

Snellville, Georgia—(DeKalb County) Office and home under construction, rent free. Community will support doctor. Contact: Mr. Ralph Head, Snellville, Georgia. (pop. 500).

Temple, Georgia—(Carroll County) Office space available. Either rent or purchase home. Two hospitals easily accessible from Temple. Contact: Mr. L. G. Lyell, Temple, Georgia. (Pop. 900).

Tifton, Georgia—(Tift County) Local hospital available. Housing available at reasonable cost. Need GP and EENT. Contact: Mrs. Agnew Andrews, Tifton, Georgia. (pop. 15,000).

Thomson, Georgia—(McDuffie County) Office space in modern building, steam heat, air conditioned. Can supply office furniture if necessary, carpets for floors, etc. Can also supply janitor service. Contact: Mr. G. C. Fite, Knox Building, Thomson, Georgia. (pop. 3,100).

Unadilla, Georgia—(Dooly County) Hospital in county. Office space available or will build small clinic and let doctor rent or buy. Housing will be provided, rent or buy. Guarantee a good doctor will do well. Contact: Mr. E. H. Conner, Unadilla, Georgia. (pop. 1,200).

Warner Robins Air Force Base, Georgia—(Bibb County) Vacancy for a medical officer (occupational medicine) GS-12, \$7,040 per annum. Also for medical officer (general supervisory) GA-13, \$8,360 per annum. Contact: Karl McPherson, Chief, Civilian Personnel Division, Warner Robins, Air Force Base, Warner Robins, Ga.

Warthen, Georgia—(Washington, County) Office space available for rent. Full time physician would have more work than he could do. Contact: Mrs. Macon Warthen, Warthen, Georgia. (pop. 200).

Watkinsville, Georgia—(Oconee County) \$5,000 loan available to doctor interested, free to construct office, rent free. Contact: Mr. Frank E. Stancil, Watkinsville, Georgia. (pop. 800).

Whigham, Georgia—(Grady County) New clinic. Housing available, buy or rent. 52,000 raised for physician to locate in Whigham. Contact: Mr. N. Z. Trulock, Whigham, Georgia. (pop. 700).

Winder, Georgia—(Barrow County) 40-bed hospital recently opened. Office space available for rent. Adequate housing available. Need GP's, surgeon. Contact: Mr. W. C. Harris, Winder, Georgia. (pop. 4,604).

Atlanta, Georgia—To General Practicing Physician and/or druggist. Complete active and profitable drug store with fountain and lunches, also offices in rear for physician. Doctor-owner is leaving the city and will turn over to purchaser all patients. General practice is producing cash income in excess of \$1,000.00 per month, in addition to charge accounts, the doctor represents four industrial accounts also. Call Mr. Kessler—CH. 6940 or LA. 6891; Corbin & Company, 815 Candler Building, Atlanta.

Doraville, Georgia (DeKalb County). Hospital in nearby Chamblee, small clinic

in Doraville for rent. New homes being built \$8,950.00 up. Grammar-high school. Social and recreational facilities. Population sufficiently large enough to support physicians. (County pop. 30,900). Contact: Mr. George W. Walker, City Clerk, Doraville, Georgia.

Villa Rica, Georgia (Carroll County) New 24 bed HB hospital to be built soon. Now have seven bed hospital. Office available for lease, reasonable. Housing available at reasonable cost. 12 grade accredited school. (Pop. 3,200). Contact: Mr. Edgar P. Candler, Villa Rica, Georgia.

Buchanan, Georgia—(Haralson County) No physicians in area; 20 bed hospital, not in use, may be purchased at give away price. Housing available rent or buy reasonably. Need two doctors to run hospital or clinic, as they so desire. Contact: Mr. P. G. Camp, Buchanan, Ga.

Americus, Georgia—(Sumter County) Population 11,367, county population—24,208. About to be without a practicing Negro physician; two Negro schools with an enrollment of 1355; two hospitals, 140 beds, 19 doctors; housing available reasonably; Americus is a very prosperous community with a large number of business establishments. Contact: Mrs. Emma G. Anderson, 213 Forrest St., Americus, Georgia.

Physicians Being Released By Navy

Moore, Jr., Wm. W., M.D.
133 Doctors Bldg., (Apr. 13, 1954)
Atlanta, Ga.

Murphy, Jr., Michael V., M.D.
150 Huntington Rd., N. W., (Apr. 14, 1954)
Atlanta, Ga.

Dupree, John T., M.D.
Gordon, Ga. (Apr. 14, 1954)

Pound, William E., M.D.
15 Novarro Apts., Macon, Ga. (Apr. 14, 1954)

Arnold, McAlpin H., M.D.
Elberton, Ga. (Apr. 14, 1954)

McClelland, Warren S., M.D.
31 28th St., N. W., (Apr. 25, 1954)
Atlanta, Ga.

Mann, David S., M.D.
Medical Bldg., Albany, Ga. (Apr. 26, 1954)

Powell, Fincher C., M.D.
124 Mimosa Pl., Decatur, Ga. (Apr. 26, 1954)

Moore, Jr., Victor A., M.D.
Naylor Hall, Roswell, Ga. (Apr. 30, 1954)

Lovett, Lindsey F., M.D.
Metter, Ga. (Apr. 30, 1954)

Crum, Barton A., M.D.
11 Daniel Dr., (May 6, 1954)
Gainesville, Ga.

The following physician being released April 29, 1954, desires work or training in Georgia: Lt. Francis B. Adams, Jr., Naval Hosp., Mare Island, Vallejo, Calif. (home: 300 First South St., Seneca, S. C.) Type of work or training: General or Pediatric Surgery. Graduated 1948, Emory U., one year rotating internship.

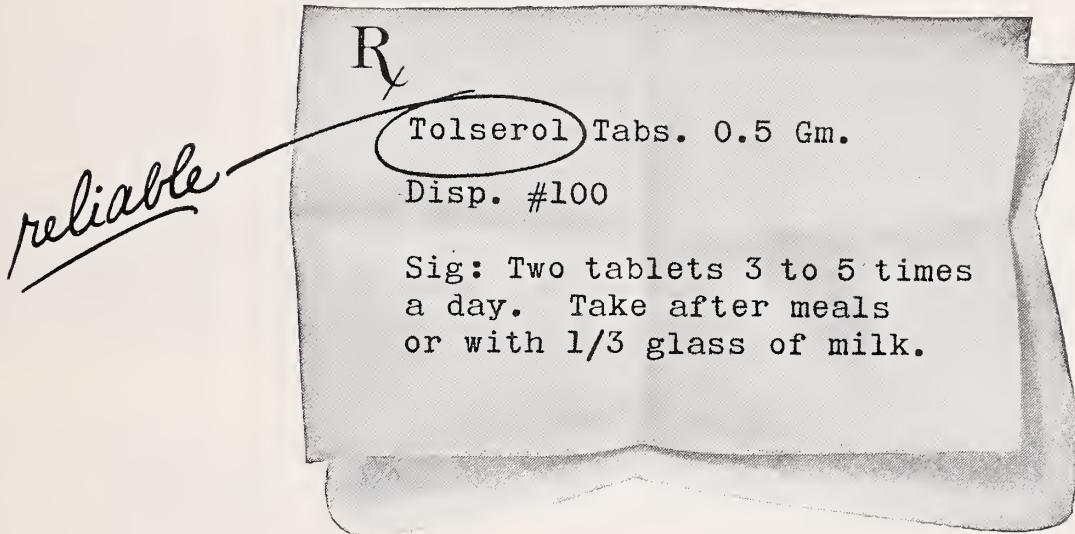
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Medical Association of Georgia
875 W. Peachtree St., N. E.
Atlanta, Ga.

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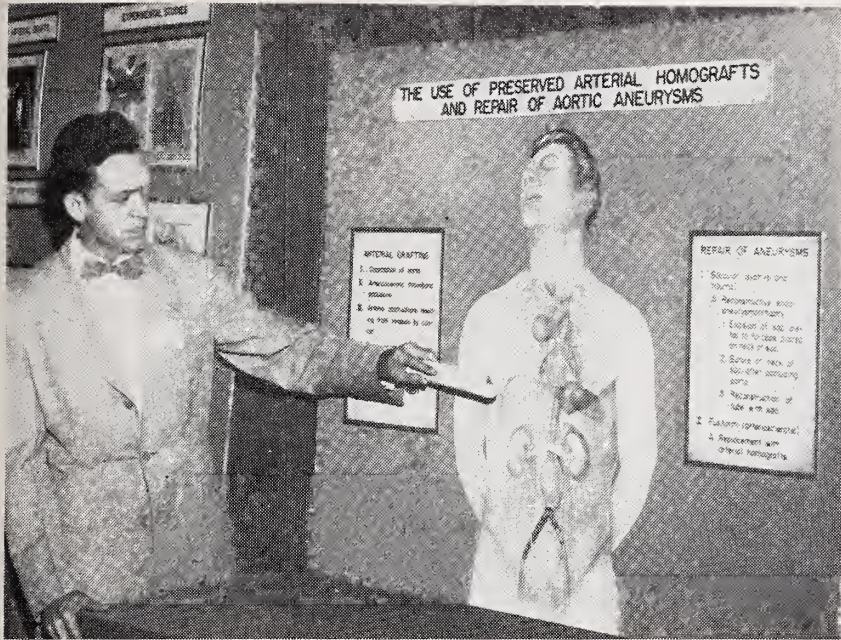
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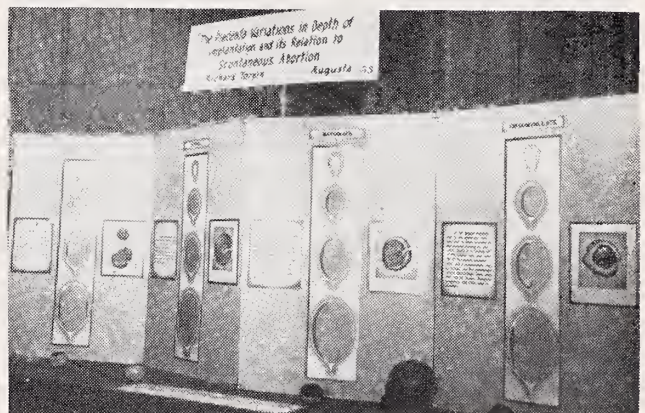
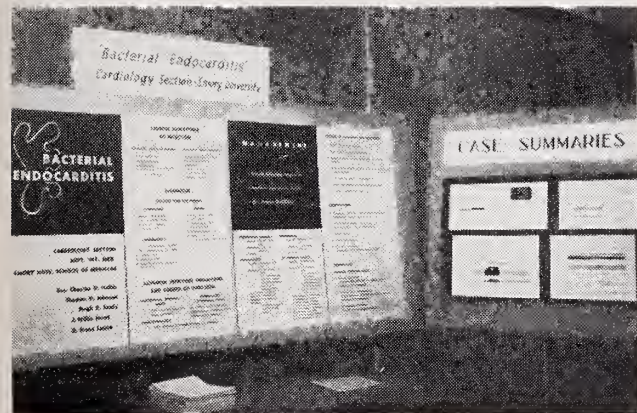
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Pictures of the Annual Session

Photos by Ted F. Leigh, M.D.

First Prize Exhibit on "The Use of Preserved Arterial Homografts and Repair of Aortic Aneurysms," by Robert G. Ellison, Augusta, Ga.



Two other prize-winning exhibits.



Speakers: AMA Pres.-Elect Martin, left, and Radiologist Neuhauser, right.



Peter B. Wright, President



David Henry Poer, Secretary-Treasurer

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President—Peter B. Wright, Augusta
 President-Elect—H. Dawson Allen, Milledgeville
 First Vice President—Willard R. Golsan, Macon
 Second Vice President—Milford B. Hatcher, Macon
 Secretary Treasurer—David Henry Poer, Atlanta

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Terms Expire December 31, 1955

C. H. Richardson, Sr., Macon
 C. L. Ayers, Toccoa, Alternate

Terms Expire December 31, 1956

Eustace A. Allen, Atlanta
 William R. Dancy, Savannah, Alternate
 Spencer Kirkland, Atlanta
 Henry Tift, Macon, Alternate

Councilors

District	Term Expires
1—Lee Howard, Savannah	1955 Session
2—George R. Dillinger, Thomasville	1955 Session
3—W. G. Elliott, Cuthbert	1955 Session
4—J. W. Chambers, LaGrange	1955 Session
5—Mark S. Dougherty, Jr., Atlanta	1956 Session
6—H. Dawson Allen, Jr., Milledgeville	1956 Session
7—D. Lloyd Wood, Dalton	1956 Session
8—Neal F. Yeomans, Waycross	1956 Session
9—W. Bruce Schaefer, Toccoa	1957 Session
10—H. L. Cheves, Union Point	1957 Session

Vice Councilors

District	Term Expires
1—Charles T. Brown, Guyton	1955 Session
2—Carl S. Pittman, Sr., Tifton	1955 Session
3—Guy J. Dillard, Columbus	1955 Session
4—Clarence B. Palmer, Covington	1955 Session
5—J. G. McDaniel, Atlanta	1956 Session
6—H. G. Weaver, Macon	1956 Session
7—Ralph W. Fowler, Marietta	1956 Session
8—James M. Hicks, Brunswick	1956 Session

9—Charles R. Andrews, Jr., Canton	1957 Session
10—J. Victor Roule, Augusta	1957 Session

Executive Committee

Peter B. Wright, President, Augusta
 William Harbin, Past President, Rome
 H. Dawson Allen, President-Elect, Milledgeville
 David Henry Poer, Secretary-Treasurer, Atlanta
 H. L. Cheves, Chairman of Council, Union Point
 J. W. Chambers, Member of Council, LaGrange

Committee on Auditing and Appropriations

Terms Expire 1955 Session

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 D. Lloyd Wood, Dalton
 Mark S. Dougherty, Jr., Atlanta

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J. W. Palmer	President, 1918-1919
C. K. Sharp	President, 1928-1929
William R. Dancy	President, 1929-1930
M. M. Head	President, 1932-1933
C. H. Richardson	President, 1933-1934
Clarence L. Ayers	President, 1934-1935
B. H. Minchew	President, 1936-1937
Grady N. Coker	President, 1938-1939
J. C. Patterson	President, 1940-1941
Allen H. Bunce	President, 1941-1942
James A. Redfearn	President, 1942-1943
W. A. Selman	President, 1943-1944
Cleveland Thompson	President, 1944-1946
Ralph H. Chaney	President, 1946-1947
Enoch Callaway	President, 1949-1950
A. M. Phillips	President, 1950-1951
W. F. Reavis	President, 1951-1952
C. F. Holton	President, 1952-1953
William Harbin	President, 1953-1954

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(One member appointed annually to serve for 3 years)

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Thomas W. Goodwin, Augusta
David Henry Poer, Atlanta
Peter B. Wright, Augusta

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Carl C. Aven, Atlanta (1953-55)
Joseph D. McElroy, Atlanta (1953-56)
Mr. Roy V. Harris, Legal Advisor, Augusta

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E. R. Pund, Augusta (1953-55)
Julian Quattlebaum, Savannah (1954-55)

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W. F. Reavis, Waycross William Harbin, Rome

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H. L. Erwin, Dalton (1953-55)
Hoke Wammock, Augusta (1954-57)

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B. H. Hand, LaGrange (1954-57)
R. F. Spanjer, Cedartown (1954-55)
T. F. Sellers, ex-officio, Atlanta
Rufus Payne, Augusta

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Tom McPherson, Atlanta Eugene Griffin, Atlanta
C. M. Mulherin, Augusta Howard J. Morrison, Savannah
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Hugh Bickerstaff, Columbus George Alexander, Forsyth

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Shelley Davis, Atlanta W. G. Elliott, Cuthbert
Willard Golsan, Macon Bruce Schaefer, Toccoa

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W. F. Jenkins, Columbus Kirk Shepard, Thomasville
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Lester Harbin, Rome *Executive Committee

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2—H. B. Jenkins, Donalsonville
4—Clarence B. Palmer,
Covington
5—Sterling H. Jernigan, Atlanta

Districts

6—E. B. Claxton, Dublin
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Rafe Banks, Gainesville W. B. Fackler, Jr., LaGrange
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(Appointed annually)

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Carter Smith, Atlanta S. A. Garrett, D.D.S., Atlanta
T. F. Sellers, Atlanta Charles C. Rife, D.V.M.,
L. Minor Blackford, Atlanta Atlanta

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Carrollton

FLORIDA: J. W. Chambers, LaGrange, and R. M. Joiner,
Moultrie

SOUTH CAROLINA: Howard J. Morrison, Savannah, and
R. C. McGahee, Augusta

TENNESSEE: William R. Dancy, Savannah, and R. N.
Little, Summerville

State Board of Health

First District: James M. Byne, Jr., Waynesboro, Sept. 1,
1957; Second District: A. G. Funderburk, Moultrie, Sept. 1,
1957; Third District: R. C. Montgomery, Butler, Sept. 1,
1954; Fourth District: M. M. Head, Zebulon, Sept. 1, 1955;
Fifth District: Spencer A. Kirkland, Atlanta, Sept. 1, 1954;
Sixth District: A. M. Phillips, Macon, Sept. 1, 1956; Seventh
District: Fred H. Simonton, Chickamauga, Sept. 1, 1956;
Eighth District: C. J. Malloy, McRae, Sept. 1, 1956; Ninth
District: R. Lee Rogers, Chairman, Gainesville, Sept. 1, 1956;
Tenth District: Thos. W. Goodwin, Augusta, Sept. 1, 1955;
Georgia Dental Association—J. M. Hawley, Columbus, Sept.
1, 1958, J. G. Williams, Atlanta, Sept. 1, 1958; *Georgia Phar-
maceutical Association*—J. B. Butts, Milledgeville, Sept. 1,
1959; W. W. Webb, Leslie, Sept. 1, 1959.

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sell, Winder; Rufus A. Askew, Atlanta; W. H. Powell, Hazle-
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Gibson Cornwall, Fitzgerald T. G. Peacock, Milledgeville

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for an immediate response*

THROUGHOUT the history of medicine, wine—the classic beverage of moderation—has been widely but empirically considered to be a reliable stimulant to the sense of taste.

During the past few years, as part of a scientific study of wine chemistry and physiology, American medical investigators have approached this matter objectively. They have conducted extensive laboratory and clinical tests, and learned that there is indeed a physiological rationale for the use of wine in anorexia*.

Unlike alcohol itself, which depresses appetite and olfactory acuity, wine has a striking and often valuable effect as a stimulant. Largely because of its natural tannins and organic acids, table wine heightens the ability of a patient to detect faint aromas, to enjoy the flavors of food, and to partake more substantially of needed nutriment.

In anorexic patients, the prescription of such wine in moderate amounts has quickly brought a significant rise in caloric intake and a welcome increase in body weight.

Wine's mild relaxant qualities, observed by many generations of physicians, may also be important in the care of many patients whose lack of appetite stems primarily from tenseness and anxiety.

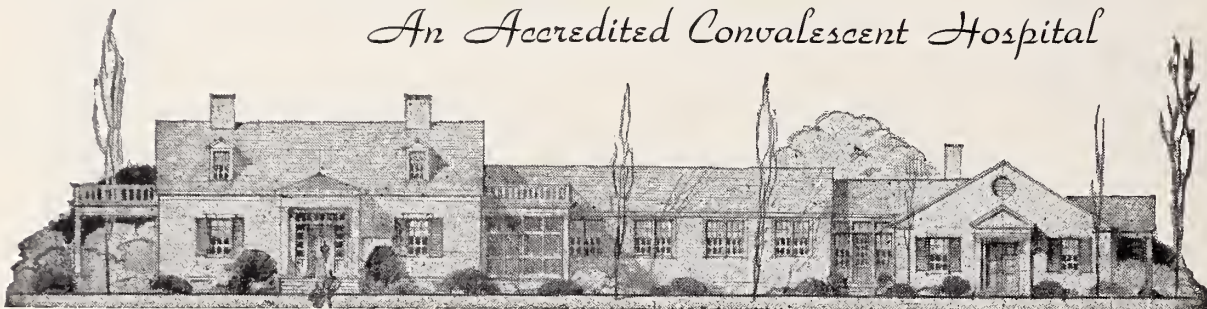
In addition to its physiological effects, wine can bring an incalculable psychological boost to the patient by adding a touch of color and grace to his diet—by making him feel that he is having "something special"—that he is being treated as a person rather than as a case.

The excellence of California's wines makes them appealing to all, including your connoisseur patients. Their economy makes it possible to prescribe these appetite-stimulating beverages without burdening the patient's budget. Wine Advisory Board, 717 Market Street, San Francisco 3, California.

*Research information on wine is available upon request.

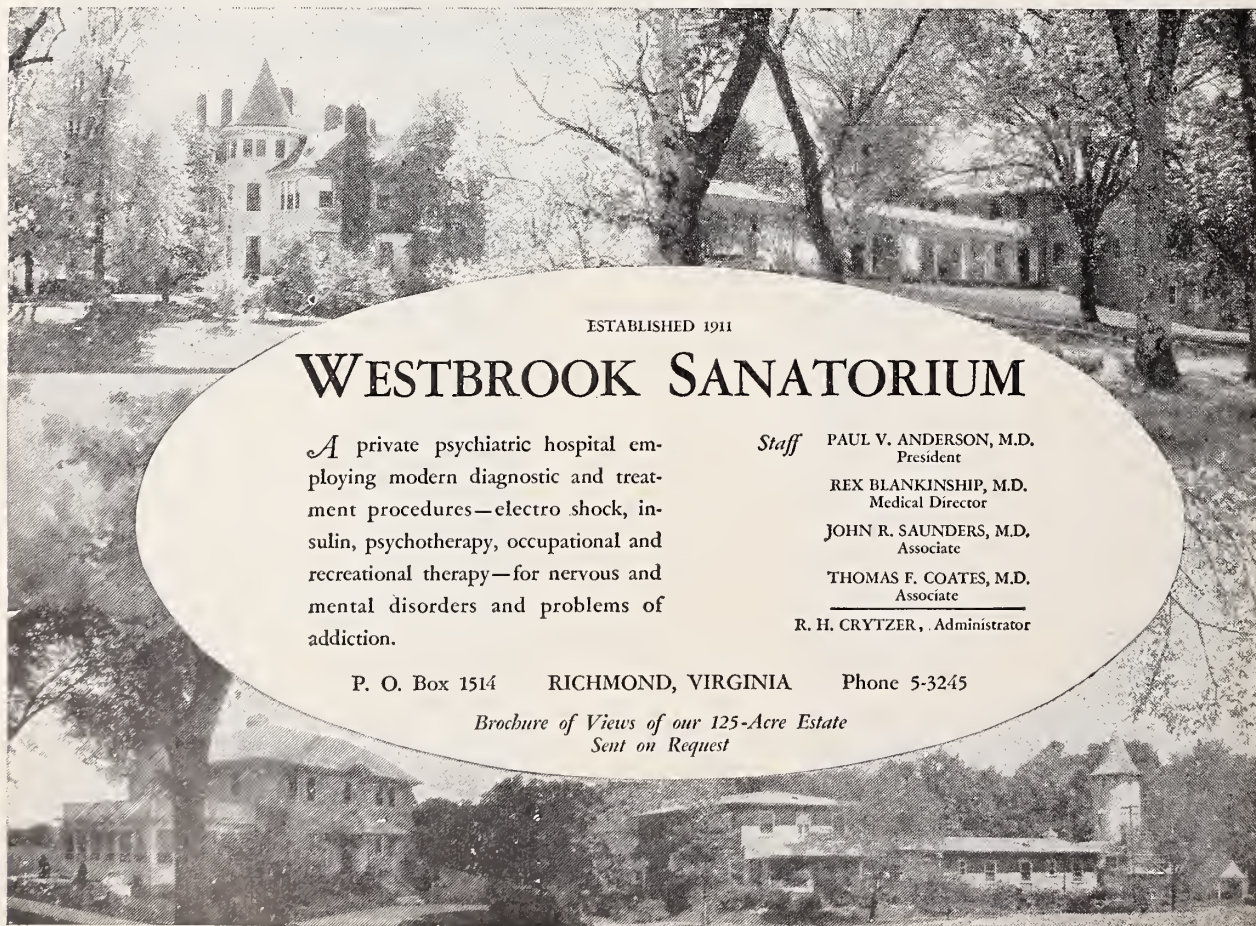
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THOMAS F. COATES, M.D.
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SOCIETIES

SECOND DISTRICT MEDICAL SOCIETY held its semi-annual meeting in April in Moultrie. Officers elected at this meeting were as follows: JOHN F. MCCOY, Moultrie, president; CARL PITTMAN, JR., Tifton, vice-president; and JULIAN NEAL, Thomasville, secretary-treasurer. JOSEPH SKOBBA, Atlanta, was the guest speaker. He discussed the role of psychiatry in the general practice of medicine. OSCAR M. MIMS, Thomasville, and FREDERICK H. THOMPSON, Albany, were also featured on the program. Following the meeting, the members, their wives and guests had dinner at the Glen Arven Country Club.

SIXTH DISTRICT MEDICAL SOCIETY met April 14, 1954 in Milledgeville with Baldwin County Medical Society as host. Those presenting scientific papers were ROBERT C. MAJOR, Augusta, HARRY B. O'REAR, Augusta, JOHN MARTIN, Macon, and R. W. McALLISTER, Macon. The Woman's Auxiliary, with Mrs. James Baugh in charge, met the same afternoon. After the business session the members of the Sixth District Medical Society and their wives had dinner at Tony's Boat House Restaurant.

SEVENTH DISTRICT MEDICAL SOCIETY met in April in Rome with the Floyd County Medical Society as host. Those presenting scientific papers were RAYMOND CORPE, Rome, WALTER KETCHUM, Rome, J. J. ALLEN, Trion, LESTER HARBIN, Rome, and ROBERT BLACK, Rome; WILLIAM HARBIN, Rome, President of the Medical Association of Georgia, addressed the meeting also. The meeting was followed by a barbecue at the Coosa Country Club.

EIGHTH DISTRICT MEDICAL SOCIETY met recently at the Golf Club, Douglas. Those reading scientific papers were T. L. PARKER, SAGE HARPER, and H. L. JOINER, all of Douglas. The scientific program and business session was followed by dinner for the Society and visitors.

The BARTOW COUNTY MEDICAL SOCIETY held its quarterly meeting at the home of Dr. and Mrs. HARVEY HOWELL in Cartersville recently. ROSS WHATLEY, Cartersville, spoke to the group on cardiovascular disease, its diagnosis and treat-

ment. SAM HOWELL was made an Honorary Life member at this meeting.

CARROLL-DOUGLAS-HARALSON MEDICAL SOCIETY met in Douglasville in April; speakers at this meeting included M. HINES ROBERTS, Atlanta, and Mr. John F. Kiser of the Medical Association of Georgia Headquarters office, Atlanta.

The CHEROKEE-PICKENS MEDICAL SOCIETY met recently in Jasper. Those presenting scientific papers were CHARLES R. ANDREWS, Canton, CALVIN SANDISON, Atlanta, GRADY N. COKER, Canton, and WILLIAM G. WHITAKER, Atlanta. PETER B. WRIGHT, President-Elect of the MAG, and DAVID HENRY POER, Secretary-Treasurer of the MAG, also spoke. After the meeting adjourned the physicians and their wives were guests at the home of Dr. and Mrs. C. J. Roper for a social hour before dinner at the V.F.W. Club in Jasper.

COLQUITT COUNTY MEDICAL SOCIETY met recently with the Vereen Memorial Hospital medical staff in Moultrie to hear LAWRENCE MATTHEWS, Moultrie, speak on the pathological diagnosis of surgically removed tissues.

HABERSHAM COUNTY MEDICAL SOCIETY and the STEPHENS COUNTY MEDICAL SOCIETY held a joint meeting recently in Clarkesville for dinner and a scientific program. OLLIE T. GHENT, radiologist of the Hall County Hospital, Gainesville, presented a paper on "Cancer of the Large Intestines."

The JACKSON-BARROW MEDICAL SOCIETY met recently in Commerce. At this meeting officers were elected to serve until March 1955. They are: ALEX B. RUSSELL, Winder, president; O. C. PITTMAN, Commerce, vice-president; C. B. SKELTON, Winder, secretary-treasurer; and ALEX B. RUSSELL, delegate. PAUL BROOKSHIRE, Athens, presented a paper on acute and chronic ear infections.

TIFT COUNTY MEDICAL SOCIETY and Auxiliary met at the home of C. S. PITTMAN, SR., Tifton, to honor Mr. Aldine Rosser, former administrator of the Tift County Hospital. This was the regular "Doctor's Day" meeting of the Society.

The MERIWETHER-TALBOT-HARRIS MEDICAL SOCIETY met recently at the Warm Springs Hotel to hear an address by Admiral George B. Dowling, former Navy medical officer and now a member of the American Red Cross staff of the Southeastern Area.

PERSONALS

C. C. AVEN, Atlanta, spoke recently at a luncheon meeting of the Atlanta Junior Chamber of Commerce; he urged the Fulton County Commissioners, guests at the luncheon, to consider seriously making available the Ben Hill work camp building for use as a hospital for long-term tuberculosis patients.

ESTELLE PATILLO BOYNTON announces the re-opening of her offices for the practice of Psychiatry and Neurology at 768 Juniper Street, N. E., Atlanta.

COURTNEY CLARK BROOKS, Blue Ridge, and Miss Nina Hartness of Atlanta and Mineral Bluff were married in Waycross, March 15, 1954.

T. G. PEACOCK, Milledgeville, GUY V. RICE, Atlanta, and CARL A. WHITAKER, Atlanta, members of the Georgia Commission on Mental Health Training and Research, recently attended a Regional Conference in Nashville, Tennessee, where problems and developments in our neighboring states were discussed in great detail.

HARRY L. CHEVES, Union Point, has received notification of his election to membership in the International College of Surgeons. He will go to Chicago in September to have the degree of membership conferred upon him.

J. KENNETH COOKE, Trenton, has recently reopened his offices in the rear of the Trenton Drug Store.

RAYMOND F. CORPE, Rome, superintendent of Battey State Hospital, was principal speaker at the annual dinner meeting of the Augusta-Richmond Tuberculosis Association held in Augusta in March.

W. B. CRAWFORD, Savannah, was made an honorary member of the Hibernian Society after having been a member of that organization for more than 50 years. Presentation was made by J. C. O'NEILL, who said Dr. Crawford had "contributed immeasurably of his professional talents in effort, skill and sympathy." Among those asked for a few words at the close of the meeting was BARRON CRAWFORD, Savannah.

NORMAN CROWE, Sylvester, spoke to the biology classes at the Sylvester High School about the

profession of nursing: the requirements, training and subsequent benefits. Dr. Crowe's talk was the first of a series planned by the biology classes on the different careers in the field of science.

Two speakers at the 30th Annual Meeting of the American Heart Association in Chicago in March were EUGENE B. FERRIS, professor of medicine at Emory University, and THOMAS L. ROSS, chief of the staff at Macon City Hospital. Dr. Ferris told of the establishment by the state association of two chairs of cardiovascular research at Emory University School of Medicine and the Medical College of Georgia. Official delegates from Georgia to the assembly were JOSEPH C. MASSEE, Atlanta, LAMONT HENRY, Atlanta, ELLISON R. COOK III, Savannah, CLARENCE C. BUTLER, Columbus, and ERNEST F. WAHL, Thomasville.

F. O. GARRISON, Demorest, and J. L. WALKER, Clarkesville, attended the Annual Session of the American Academy of General Practice held in Cleveland, Ohio.

Mrs. T. J. Floyd, Sr., mother of T. J. FLOYD, JR., of Griffin died March 31, 1954 in Abbeville, Alabama.

WILLIAM H. GOOD, Toccoa, has been named 1954-55 president of the Rotary Club of Toccoa. PAUL NICHOLS, who is also a member of the Board of Directors, was named Sergeant-at-Arms. The new officers will assume their duties on July 1.

WILLIAM HARBIN, Rome, was moderator of the Educational Panel at the Rome meeting sponsored by the Better Health Council for the study of Mental Health Conditions in Georgia.

HARRY HARPER, *Augusta*, spoke at the annual Emory Alumni Medical clinic on April 9. The topic of his address was "The Use and Misuse of Digitalis."

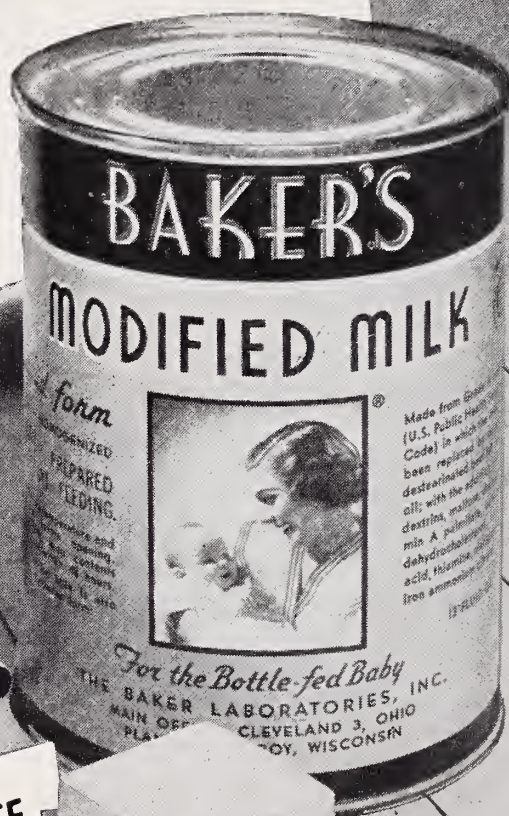
WORTH HOBBY, Atlanta, has received notification from the Board of Regents of the American College of Chest Physicians that he has been awarded a certificate of merit in recognition of his valuable services as the president of his College Chapter. The certificate will be awarded at the 10th Annual College Conference to be held in San Francisco, June 17, 1954.

CHARLES E. IRWIN, Warm Springs, was a guest speaker at the Sixth Annual Conference of Bone and Joint Surgeons held in Augusta. Local physi-

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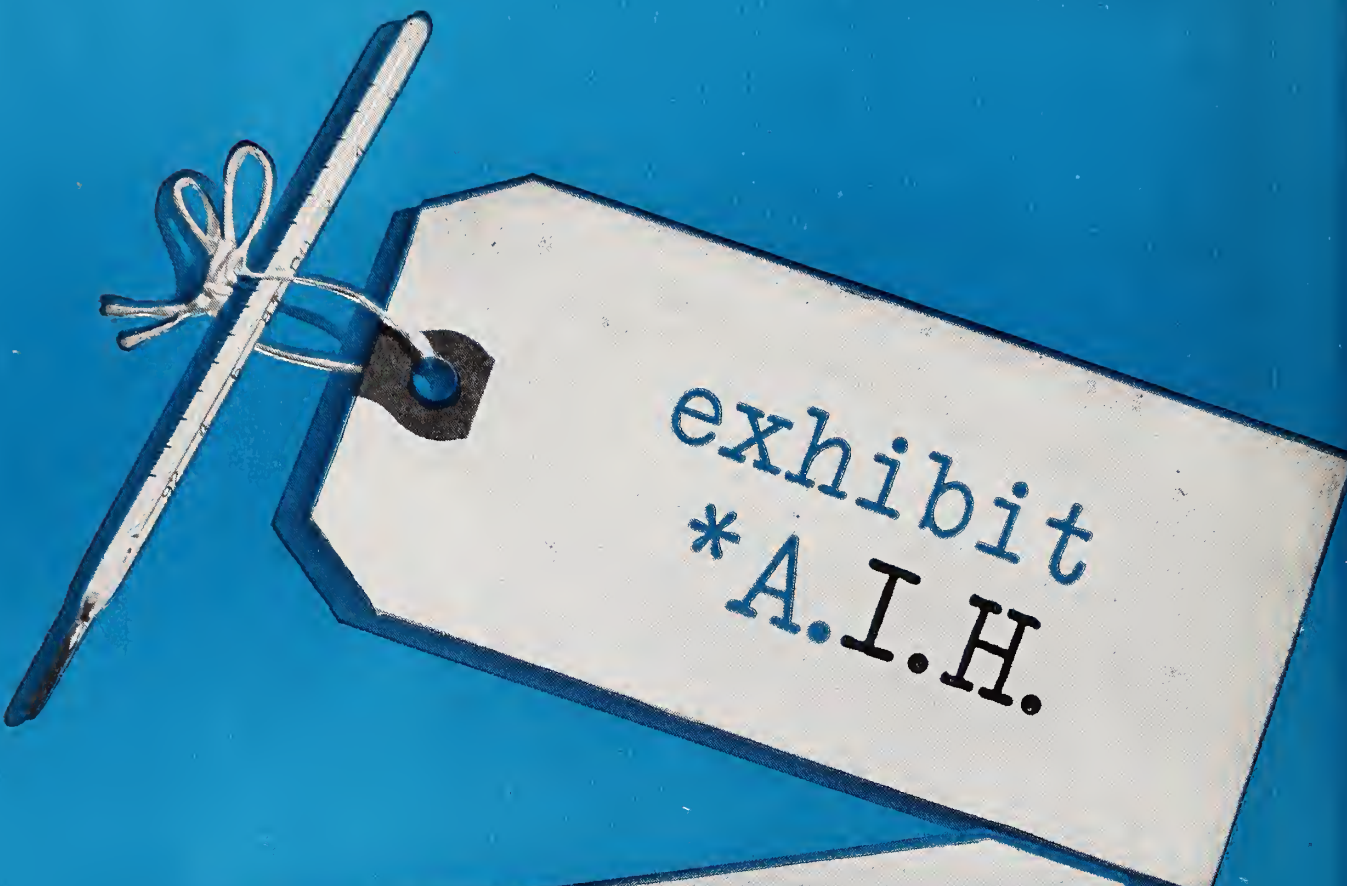


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**English, A. R., et al.: Antibiotics
Annual (1953-1954), New York, Medical
Encyclopedia, Inc., 1953, p. 70.*

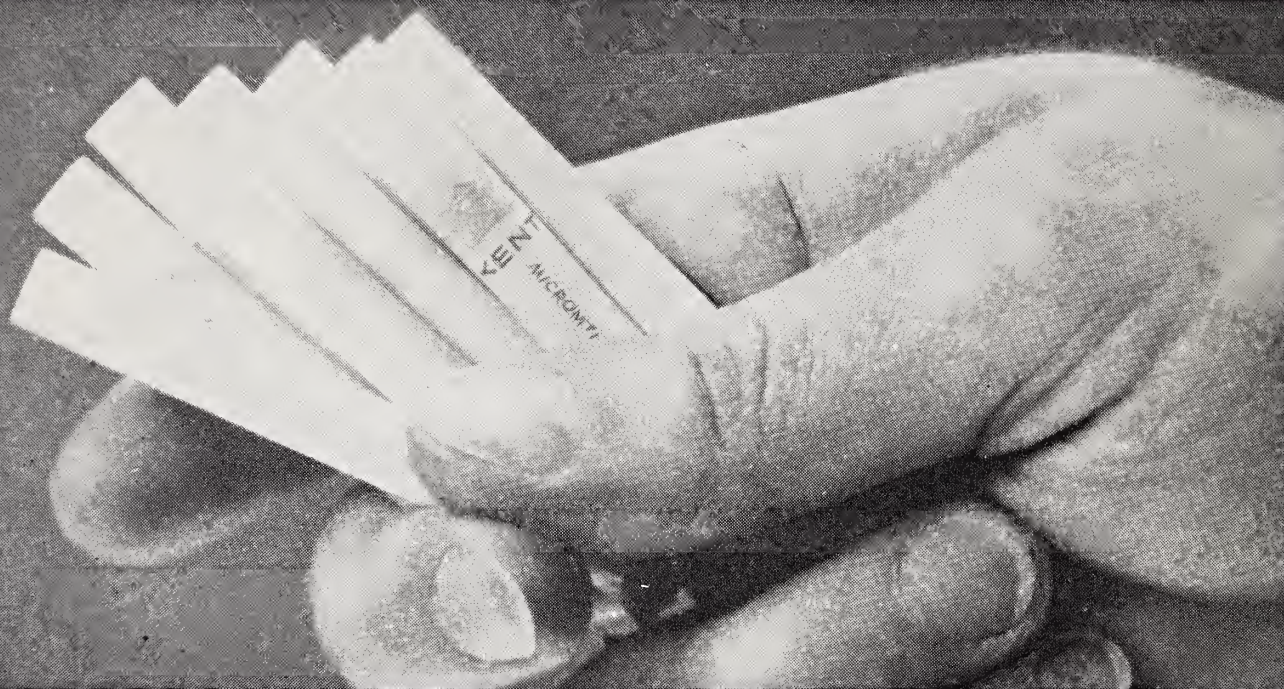


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CARL C. JONES, JR., Atlanta, addressed a meeting of the Southeastern Allergy Association with advice to smokers.

HUBERT U. KING, Dalton, has been named Young Man of the Year in Dalton for 1953. Dr. King is the Dalton-Whitfield County Commissioner of Health.

Georgia speakers at the 31st Annual Meeting of the American Orthopsychiatric Association were WILLIAM H. KISER, JR., Atlanta, who spoke on "The Utilization of Countertransference in Medical Students: An Aid in Teaching Pediatrics", and JOHN WARKENTIN, Atlanta, who spoke on "Support Through Non-Reassurance."

ROBERT O. LIPE, Camilla, has recently closed his offices in Camilla to accept a position with the American Oil Company in Saudi Arabia for two years.

L. F. LOVETT, Metter, has returned to Metter to resume his practice after service in the U. S. Navy.

A. L. MORRIS, Fairburn, has been appointed to the Board of Directors of the South Fulton Cities Hospital Authority.

T. L. PARKER, Douglas, has moved his offices to a new building on the Ocilla Highway next to the Coffee County Hospital entrance.

G. H. PERROW, Jasper, has been selected Pickens County's Man of the Year for 1953.

T. A. PETERSON, Savannah, has been named president-elect of the Association of Seaboard Air Line Railway Surgeons. J. W. PALMER, Ailey, is assistant Chief surgeon for the Association.

EDNA SMITH PORTH, Atlanta, recently addressed the American Association of University Women on the topic "Women in Medicine."

Adam S. Rankine, father of C. A. N. RANKINE, Brookhaven, died suddenly on March 12, 1954, at his home in Rahway, N. J. Burial was in Rahway.

WALTER J. REVELL, Louisville, recently moved into new offices on Seventh Street in Louisville.

C. L. RIDLEY, SR., Macon, was re-elected president of the Central Georgia Hospital Service, Inc. at that organization's annual meeting. Also re-elected was C. H. RICHARDSON, SR., vice president. Directors elected to serve for the coming year are C. L. RIDLEY, GEORGE Y. MASSENBERG, J. D. APPLEWHITE, C. H. RICHARDSON, SR., all of Macon, E. B. CLAXTON and A. T. COLEMAN, Dublin; FRANK P. HOLDER, JR., and HAROLD W. LONG, Eastman.

JOE SAM ROBINSON, Atlanta, is now associated in practice with CLAUD P. COBB, JR., and WILLIAM FEDACK in East Point.

ELI A. ROSEN, Dalton, recently addressed members of the Dalton Lions Club on the subject "Allergies."

LESTER RUMBLE, JR., Atlanta, was guest speaker at the annual observance on March 30 of Crawford W. Long Day at the University of Georgia. The title of his lecture was "One Man's Dream."

S. C. RUTLAND, Carrollton, addressed the Carrollton Lions Club in the last of a series of health programs in March.

PETER L. SCARDINO, Savannah, was recently the principal speaker at a meeting of the new members of the Savannah Chamber of Commerce. His topic was "What Chamber Membership Means to Me."

H. A. SMITH, Americus, spoke to the members of the Americus Kiwanis Club in April about the discovery of anesthesia and the developments and improvements in anesthesia as it is today.

ROBERT F. SULLIVAN, Savannah, was elected secretary of the Southern Academy of Oral Surgery at their recent convention banquet at the General Oglethorpe Hotel in Savannah.

FRANK VINSON, Ft. Valley, and Mrs. Vinson recently attended the meeting of the American Academy of General Practitioners in Cleveland, Ohio. Dr. Vinson is the new chief of staff of the Peach County Hospital succeeding J. E. HASLAM. DAN NATHAN, Fort Valley, is the new secretary of the staff.

PERRY P. VOLPITTO, Augusta, addressed the Augusta Rotarians recently, tracing man's fight against pain.

PAUL WILSON, Thomson, announces the re-

moval of his offices to a new clinic building located at 105 Whiteoak Street, Thomson.

A new electric organ has been given the Jesup

Methodist Church by the family of the late UNA RITCH YEOMANS, wife of J. W. YEOMANS, as a memorial to her.

DEATHS

BRIDGES, BENJAMIN L., 70, of Thomaston, died March 7, 1954. Dr. Bridges suffered a heart attack while riding horseback Sunday afternoon and died in the Upson County Hospital later that same day. He was an active physician, surgeon, church, civic and fraternal worker until the day of his death. Dr. Bridges was a member of the First Baptist Church of Thomaston, a Mason and Shriner, and a member of the Thomaston Kiwanis Club. After attending Loyola University at Joliet, Illinois, Dr. Bridges practiced in Morgan, Georgia, before coming to Thomaston in 1926.

JOHNSON, ROBERT WILLIAM, 65, Augusta, died March 16, 1954 after an extended illness. Interment was in the Windsor, S. C. cemetery. Dr. Johnson was a graduate of the University of Maryland Medical College, where he also taught. He practiced medicine in Baltimore for 30 years and, at one time, was superintendent of the South Baltimore General Hospital. Dr. Johnson lived in Augusta for the last ten years where he was a member of the First Baptist Church, the Order of the Eastern Star and the Masons.

KEATON, J. C., 67, Albany, died March 30, 1954 in a New Orleans, Louisiana, hospital. He had been ill for several weeks. Dr. Keaton was born in Damascus and had practiced in Albany

for 45 years. He was chief of the urological service at the Phoebe Putnam Memorial Hospital, Albany. He was a graduate in medicine of the University of Maryland and did post graduate work in urology in New York. Dr. Keaton was a member of the American College of Surgeons, the American Urological Association, a fellow of the Academy-International of Medicine and also a patron of the Smithsonian Institute, Washington, D. C. He belonged to St. Paul's Episcopal Church, the Albany Rotary Club and was a director of the Citizens and Southern Bank of Albany.

KENNEDY, R. L., 56, Metter, died at his home in Metter on April 1, 1954 after suffering a heart attack. Dr. Kennedy was the son and grandson of prominent Metter physicians. He had practiced medicine in Metter since 1924. A civic leader, Dr. Kennedy was a steward of the Metter Methodist Church, and a member of the Metter Masonic Lodge, City Board of Education and City Council. Members of the Candler-Bulloch-Evans Medical Association were honorary pallbearers.

MCELROY, STEPHEN L., 78, Ocilla, died March 9, 1954 at the Irwin County Hospital. He had been ill for several months. Dr. McElroy was born in Norcross, Georgia, in 1876 and was graduated from Atlanta Medical School in 1900. He practiced medicine in Ocilla for 54 years. Prior to his coming to Ocilla in 1907, he had practiced in Alapaha and Willacoochee for a number of years. Dr. McElroy was a Mason, a Shriner, and a member of the Ocilla City Council for several years.

Resolution on the Death of John C. Keaton

Whereas, Dr. John C. Keaton was for many years a beloved, respected, highly capable, and very active urologist, a fine physician, and a member of the Medical Association of Georgia; the Ware County Medical Society, in regular active session, has voted to pass a resolution on his death. The people of Albany and the surrounding territory have lost a great physician. We have lost a colleague for whom we had great love and respect. Dr. Keaton will be long remembered in

South Georgia by laymen and physicians. The Ware County Medical Society wishes to express its profound grief and sorrow at the loss of this great man. We wish also to express to his widow our sincere condolences.

Signed,

Arthur M. Knight, Jr., M.D.
Secretary-Treasurer
Ware County Medical Society

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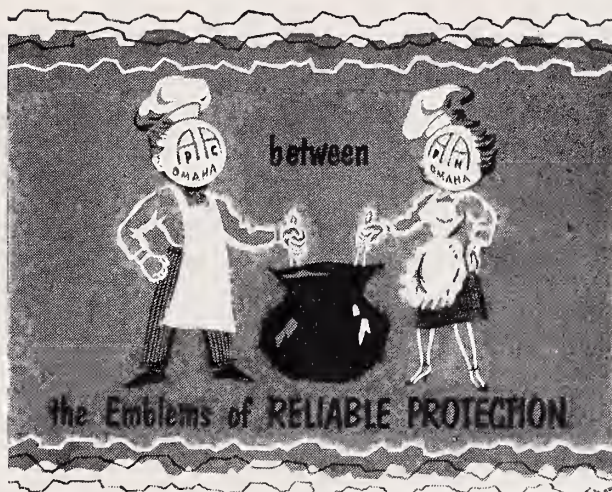
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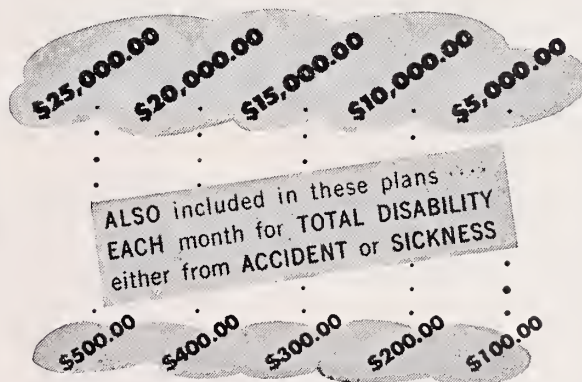


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The JOURNAL *of the* **MEDICAL** **ASSOCIATION** **OF GEORGIA**

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MANUSCRIPTS

Articles are accepted for publication on the condition that they are contributed solely to this **Journal**. Manuscripts should be typewritten, double-spaced and the original, not the carbon copy, should be submitted. Receipt of manuscripts will be acknowledged and unused manuscripts returned. Used manuscripts will be returned only if requested.

STYLE

Ordinarily articles should not exceed 3,000 words. Only under exceptional circumstances will articles of over 4,000 words be published. Footnotes, bibliographies and legends should be typed on separate sheets, double-spaced. Bibliographies should conform to the style of the Quarterly Cumulative Index published by the American Medical Association—i.e., name of author, title of article, name of periodicals with volume, page, month, day of month if weekly and the year. They should be listed in alphabetical order and numbered in sequence. Example: 1. Jones, S. R.: Spontaneous Epistaxis, Arch. Int. Med., 36:434 (Dec.) 1946.

NEWS NOTES

District and County Medical Societies, Association members and readers are invited to send in any news items of general concern to members of the Medical Association of Georgia.

REPRINTS

Requests for reprints should be made direct to Mr. T. D. Thompson, Franklin Printing & Mfg. Co., 675 Drewry Street, N.E., Atlanta, Georgia. Reprints must be ordered within 30 days after publication, since all type will be destroyed after that time.

ILLUSTRATIONS

Illustrations, tables, etc., should bear the author's name and figure number. Used photographs, drawings and cuts will be returned after publication only if requested. The cost of reproduction of illustrated material for publication will be borne by the author and the engraver will bill the author for this expense.

GENERAL POLICY

The Editor and members of The **Journal** Editorial Board will permit authors to have as wide a latitude as the general policy of the **Journal** and the demands on its space permit. The right to reduce, revise, or reject any material submitted for publication is always reserved. The **Journal** is not responsible for statements made by any contributor. All communications regarding editorial, advertising, subscription and miscellaneous matters should be sent The Editor, 875 West Peachtree Street, N.E., Atlanta, Ga.

ADVERTISING

All advertising copy approved by the Councils of the American Medical Association shall be acceptable for publication. Other advertising copy may be accepted subject to the approval of the Editor and members of the Editorial Board. All copy or plates must reach the **Journal** office by 10th of the month preceding publication. General and classified advertising rates will be furnished on request.

MEDICAL EDITING SERVICE

If in the opinion of the **Journal** Editorial Board, material submitted for publication could be improved by a Medical Editing Service, the Editor will contact the author for his approval. Association members needing assistance in preparation of material for publication may also use this service. A reasonable charge is made for this service and the cost of this will be borne by the author.

JOURNAL of The Medical Association of Georgia

JUNE • 1954

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Joint Memorial Service... Section on Industrial Medicine... Registration
General Health... Committee... Pathogenesis of Poliomyelitis... Scientific
Exhibits... Woman's... Panel Discussion... Voting Booths
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Session... Vein Stripping... Announcements... President-Elect... T
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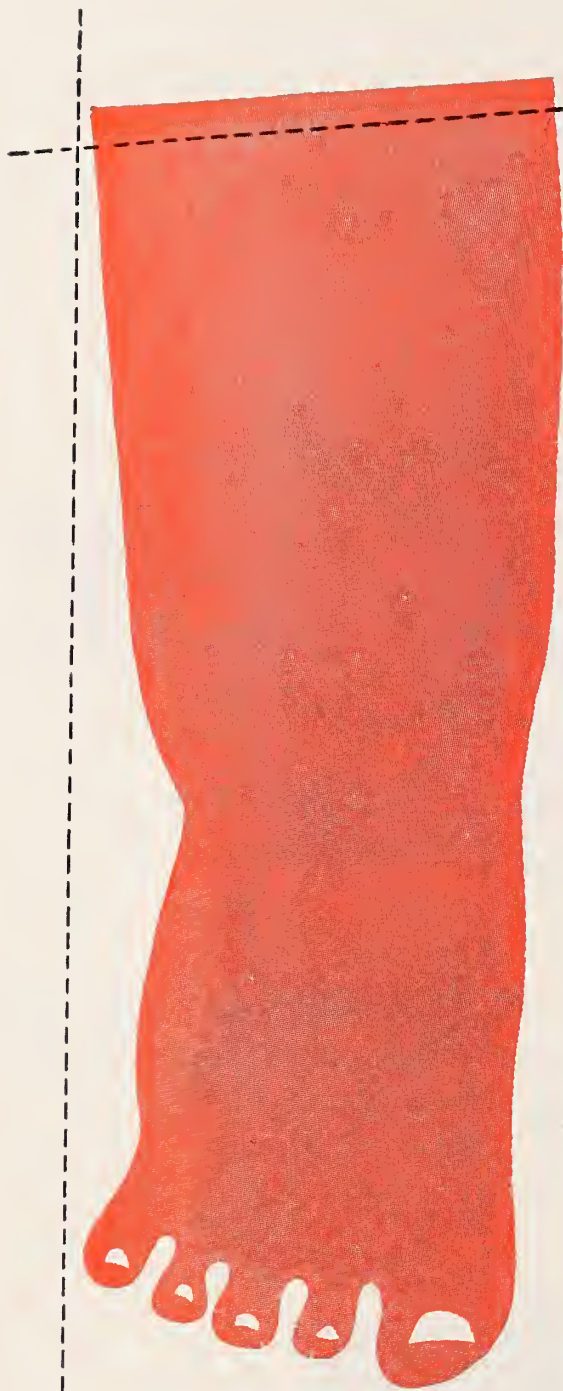
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*Stead, E. A., Jr., in Cecil, R. L., and Loeb, R. F.: Textbook of Medicine, ed. 8, Philadelphia, W. B. Saunders Co., 1951, p. 1065.

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Delegates... Alumni Dinner Meeting... General Clinical Session...
International Memorial Service... Section on Industrial Medicine... Register
of Health... Committee on Pathogenesis of Poliomyelitis... Scientific
Exhibits... Woman's Society... Panel on... Voting Booths...
Scratch Fever... Address... Tournament... 104
Annual Session... Symposium... Section on Urology... Guest Speaker
Physiologic Exhibits... Address... Tumors of the Colon...
Fictional Bulletin Board... Address... Delegates... the A.M.A...
Session... Vein Stripping... Announcements... President-Elect...
Editor and the Law... Pediatrics Speaker... Election of Officers...

COVER — The cover combines the talents of our photographic editor and Miss Kathleen Mackay, medical illustrator of Emory University School of Medicine. It is an attempt to blend scientific medicine with organized medicine.

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The JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA, established 1911. Owned, edited and Copyright, 1954 by the Medical Association of Georgia, 875 West Peachtree Street, N.E., Atlanta, Georgia. Published monthly under the direction of the Council of the Association. Subscription rates: \$5 per year; \$1 per single copy. Entered as second-class mail at the post office at Atlanta, Georgia, under the Act of March 3, 1879. Accepted for mailing for the general rate of postage provided for in Section 1103, Act of October 6, 1917, authorized November 14, 1928.



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1. Thorn, G. W., *et al.*, *New England J. Med.* 248:632, April 9, 1953.

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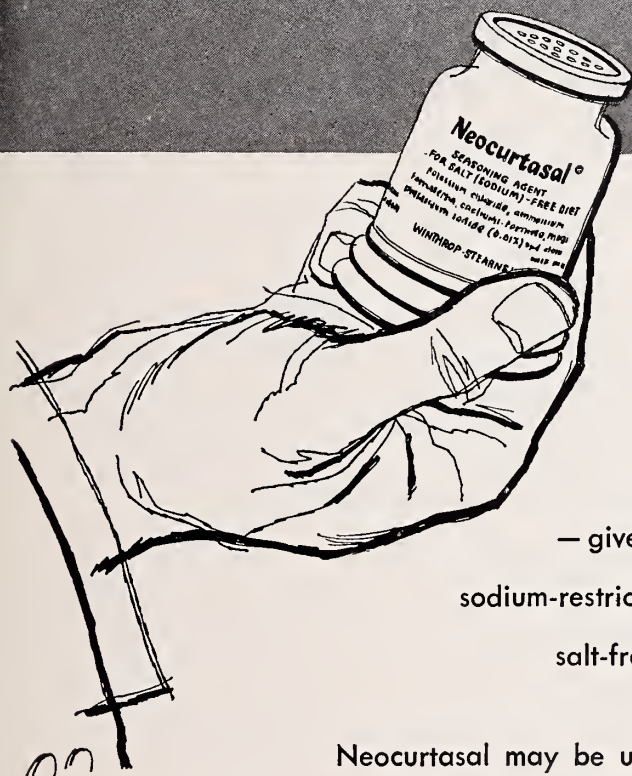
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1. Heller, E. M.: The Treatment of Essential
Hypertension. *Canad. Med. Assn.
Jour.*, 61:293, Sept., 1949.

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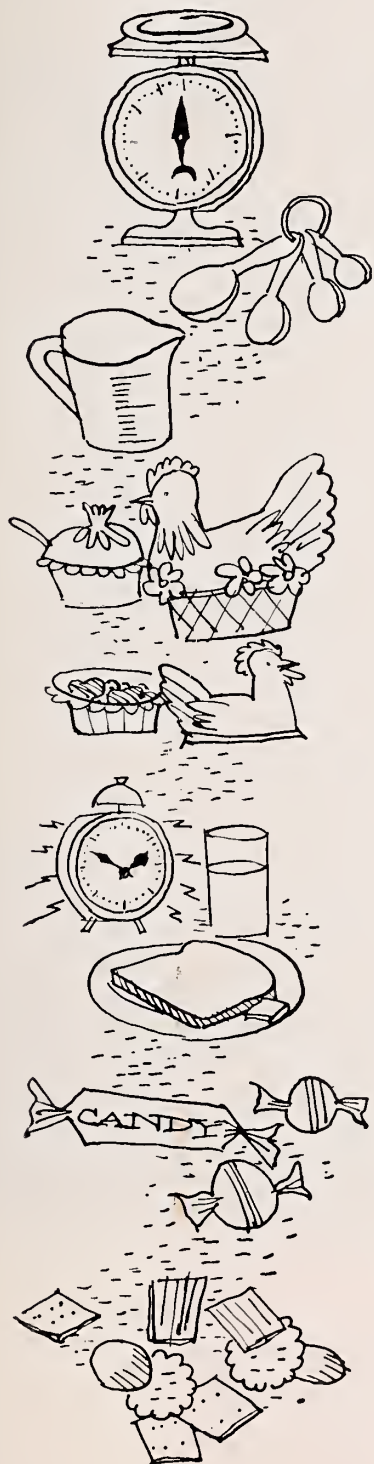
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Try to adapt favorite recipes to the diabetic diet. Then select vegetables, beverage, and fruit or dessert to complete the diet prescription for the meal.

Suggest that measured portions be served in dishes that fit the serving. A small portion on a large plate is not a happy prospect.

Where possible, let your patient use a food exchange list. He'll delight in the variations it provides.

Away from home—

Explain that insulin demands food with the urgency and regularity of an alarm clock. If a dinner party will be late, suggest a light snack at the usual mealtime with a corresponding caloric reduction in the delayed meal.

Allow extra carbohydrate for extra activity. And have your patient carry hard candies as a precaution against insulin reaction.

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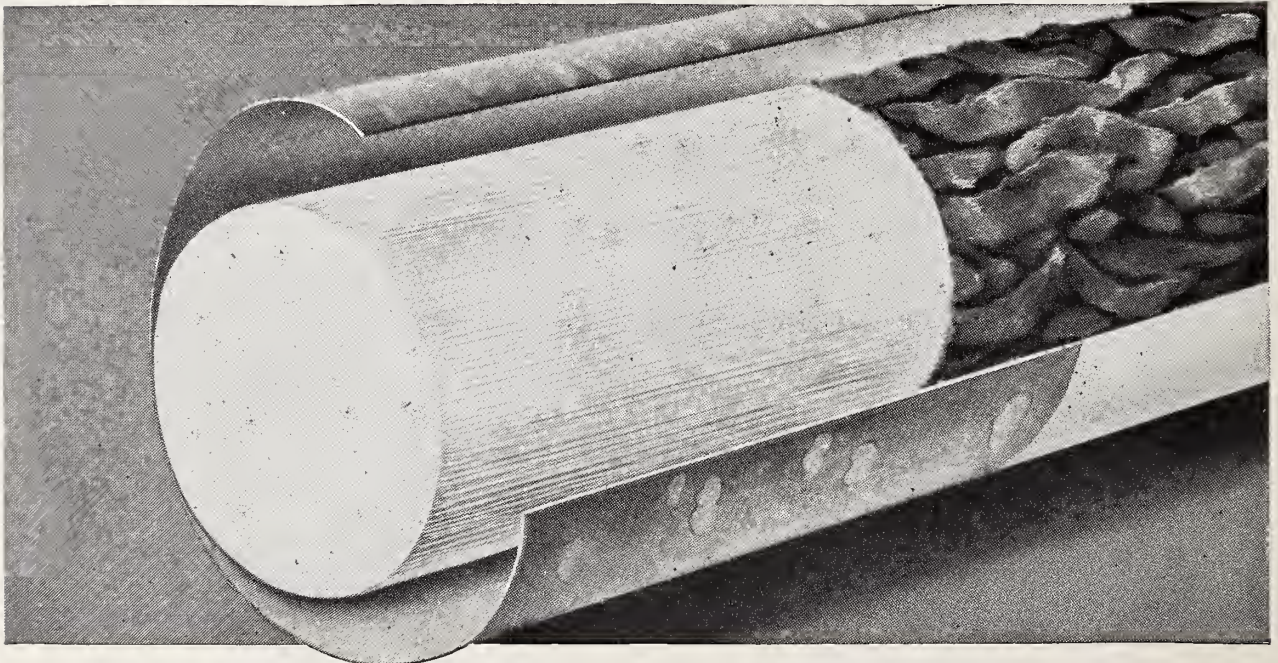
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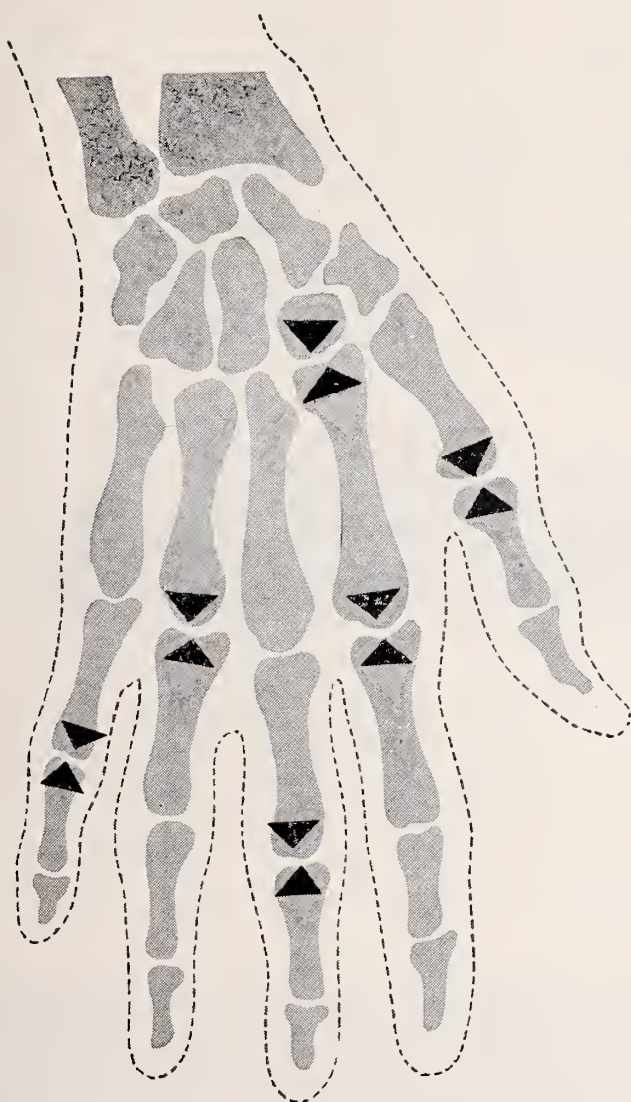


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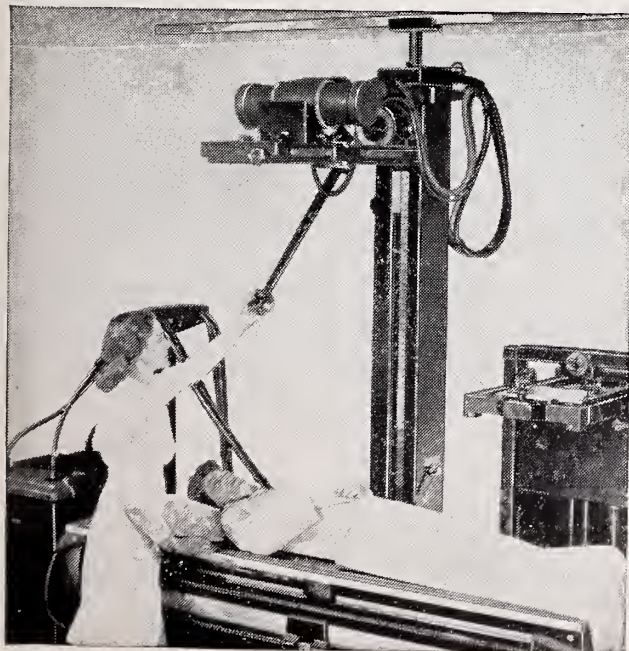
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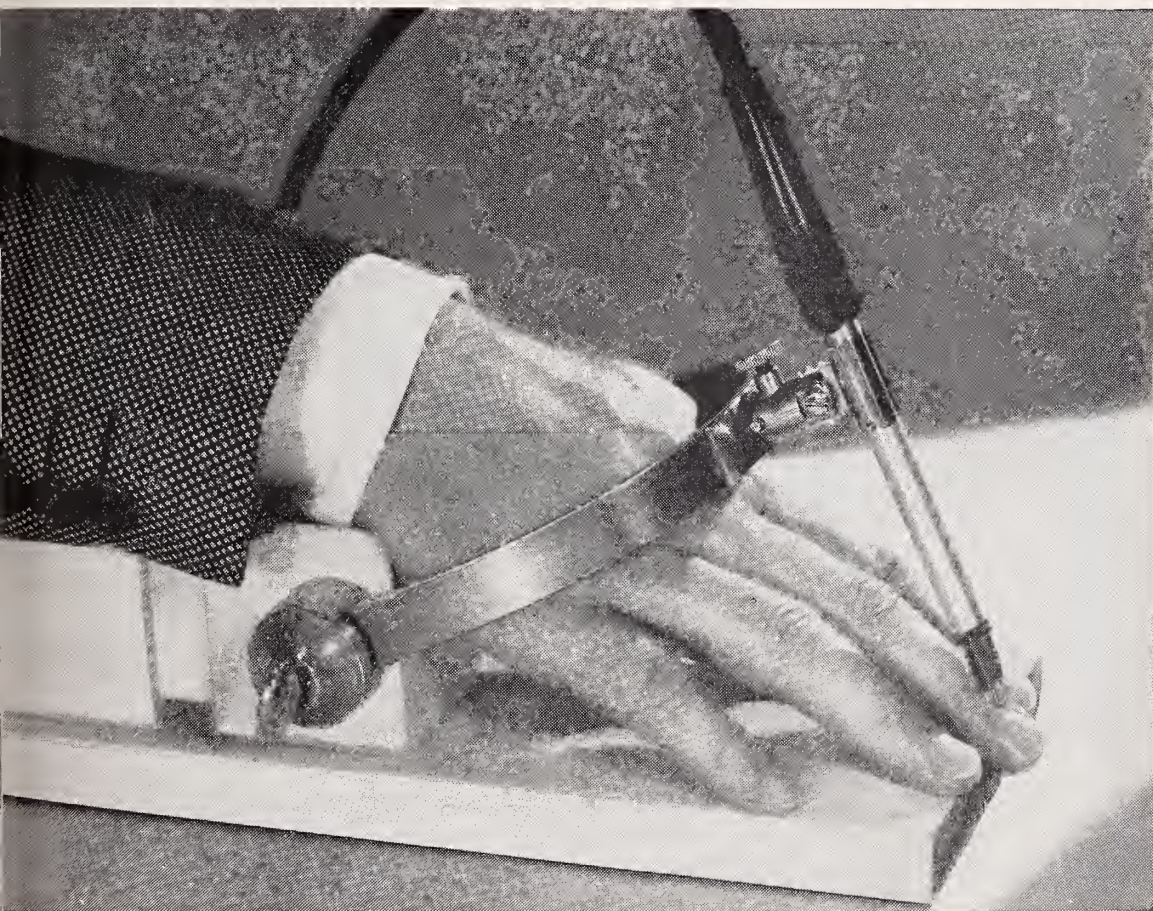
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Official Proceedings

104th Annual Session

of the

MEDICAL ASSOCIATION of GEORGIA

Macon, May 2-5, 1954

First Session, House of Delegates

SUNDAY, MAY 2, 1954

The House of Delegates was called to order by President Harbin at 2:15 p.m. in the Main Floor, Auditorium, Macon. The invocation was given by Secretary-Treasurer David Henry Poer.

Upon motion duly made and seconded, Credentials Committee Chairman Henry H. Tift accepted the official Delegates attendance slips in lieu of a roll call as an official attendance record and reported a quorum present.

Attendance

George H. Alexander, Forsyth; Herbert Alden, Atlanta; Eustace A. Allen, Atlanta; H. Dawson Allen, Milledgeville; M. F. Arnold, Hawkinsville; C. Raymond Arp, Atlanta; Joe J. Arrendale, Cornelia; C. C. Aven, Atlanta; C. L. Ayers, Toccoa; Darrell Ayer, Atlanta; Rafe Banks, Jr., Gainesville; Helen Bellhouse, Atlanta; Robert L. Bennett, Warm Springs; J. C. Brim, Pelham; Allen H. Bunce, Atlanta; T. J. Busey, Fayetteville; H. G. Carter, Decatur; H. L. Cheves, Union Point; Grady N. Coker, Canton; Allen Collinsworth, Atlanta; A. B. Conger, Columbus; Charles T. Cowart, LaGrange; James H. Crowdis, Jr., Blakely; Norman J. Crowe, Sylvester; Ralph Davis, Rome; Hal M. Davison, Atlanta; George R. Dillinger, Thomasville; W. S. Dorrough, Atlanta; Mark S. Dougherty, Atlanta; John L. Elliott, Savannah; W. G. Elliott, Cuthbert; Ralph W. Fowler, Marietta; Charles B. Fulghum, Milledgeville; William H. Fulmer, Savannah; Elizabeth Gambrell, Atlanta; Thomas W. Goodwin, Augusta; J. A. Green, Athens; Marvin L. Greene, Jasper; Edwin M. Guffin, Bainbridge; Hugh Hailey, Atlanta; Sage Harper, Douglas; Milford B. Hatcher, Macon; Irving D. Hellenga, Toccoa; J. H. Hilsman, Atlanta; C. F. Holton, Savannah; Lee Howard, Savannah; Lee Howard, Jr., Savannah; M. A. Hubert, Athens; G. M. Hutto, Columbus; McClaren Johnson, Atlanta; Alex P. Jones, Griffin; James B. Kay, Byron; D. G. Kitchens,

Jesup; O. W. Kitchens, Byromville; Morris Kusnitz, Alamo; Lewis R. Lang, Calhoun; Albert G. LeRoy, Thomson; A. O. Linch, Atlanta; A. G. Little, Valdosta; Robert B. Martin, III, Cuthbert; Walter B. Martin, AMA President-Elect, Norfolk, Virginia; J. G. McDaniel, Atlanta; Harold P. McDonald, Atlanta; Earl T. McGhee, Dalton; Chris J. McLoughlin, Atlanta; W. A. Mendenhall, Chamblee; Joseph B. Mercer, Brunswick; J. Hubert Milford, Hartwell; W. C. Mitchell, Marietta; Charles Mulherin, Augusta; George T. Nicholson, Cornelia; Jack C. Norris, Atlanta; James F. O'Daniel, Dublin; Clarence B. Palmer, Covington; Sam E. Patton, Macon; T. A. Peterson, Savannah; W. L. Pomeroy, Waycross; A. A. Rayle, Jr., Atlanta; W. F. Reavis, Waycross; C. H. Richardson, Macon; Thomas L. Ross, Jr., Macon; Alex B. Russell, Winder; T. A. Sappington, Thomaston; W. Bruce Schaefer, Toccoa; Frank B. Schley, Columbus; T. F. Sellers, Atlanta; Glenn E. Seymour, Albany; E. D. Shanks, Jr., Atlanta; Duncan Shepard, Atlanta; Kirk Shepard, Thomasville; Fred H. Simonton, Chickamauga; Leo Smith, Waycross; R. F. Spanjer, Cedartown; C. W. Strickler, Jr., Atlanta; David R. Thomas, Jr., Augusta; D. N. Thompson, Elberton; Henry H. Tift, Macon; John W. Turner, Atlanta; W. W. Turner, Nashville; Robert Vaughn, Columbus; Virgil Williams, Griffin; D. L. Wood, Dalton; George W. Wright, Augusta; Peter B. Wright, Augusta; Neal F. Yeomans, Waycross.

Reference Committees

President Harbin appointed the following reference committees.

Reference Committee No. 1: C. F. Holton, Chairman, Savannah; A. B. Conger, Jr., Columbus; R. F. Spanjer, Cedartown; Sterling Claiborne, Atlanta; and Sage Harper, Douglas.

Reference Committee No. 2: A. M. Phillips, Chairman, Macon; George Hutto, Columbus; A. M. Collinsworth, Atlanta; G. W. Wright, Augusta; and Rafe Banks, Gainesville.

Reference Committee No. 3: Fred Simonton, Chairman, Chickamauga; Alex Russell, Winder; Ralph Davis, Rome; T. A. Peterson, Savannah; and Henry Tift, Macon.

Reference Committee No. 4: David R. Thomas, Jr., Chairman, Augusta; Duncan Shepard, Atlanta; Enoch Callaway, LaGrange; Leo Smith, Waycross; and T. A. Sappington, Thomaston.

Reference Committee No. 5: J. M. Byne, Chairman, Waynesboro; F. G. Eldridge, Valdosta; W. C. Mitchell, Smyrna; Clarence B. Palmer, Covington; and John Mooney, Statesboro.

President Harbin announced that nominations for Speaker were in order. J. G. McDaniel, Atlanta, nominated Thomas W. Goodwin, Augusta. There being no other nominations the motion was seconded and adopted. Milford B. Hatcher, Macon, nominated Fred Simonton, Chickamauga, as Speaker Pro-Tem. The motion was seconded and passed.

Speaker Goodwin then called for the reading and adoption of minutes of the 1953 House of Delegates. It was moved and seconded that these minutes, as published in the JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA, June 1953, be approved and the motion carried.

Speaker Goodwin called on Secretary-Treasurer Poer to introduce distinguished guests attending this session. Guests introduced were Homer Pearson, AMA Judicial Council Member, Miami, Florida, and Walter B. Martin, AMA President-Elect, Norfolk, Virginia.

Speaker Goodwin announced the next order of business to be the presentation of the annual reports of officers and committees.

(A cross reference of the officer or committee chairman presenting a report is listed below with the reference committee to which the report was referred. The full report and action by the reference committee and House of Delegates are listed under the proceedings of the Second Session of the House of Delegates.)

President's Report—William Harbin, Rome—Reference Committee No. 1.

President-Elect's Report—Peter B. Wright, Augusta—Reference Committee No. 2.

1st Vice-President's Report—J. C. Metts, Savannah—no report.

2nd Vice-President's Report with Addendum—Milford B. Hatcher, Macon—Reference Committee No. 2.

Secretary-Treasurer's Report with Addendum—David Henry Poer, Atlanta—Reference Committee No. 5.

Councilor First District Report—Lee Howard, Savannah—Reference Committee No. 1.

Councilor Second District Report—George R. Dillinger, Thomasville—Reference Committee No. 1.

Councilor Third District Report—W. G. Elliott, Cuthbert—Reference Committee No. 2.

Councilor Fourth District Report—J. W. Chambers, LaGrange—Reference Committee No. 2.

Councilor Fifth District Report—Mark S. Dougherty, Atlanta—Reference Committee No. 3.

Councilor Sixth District Report—H. Dawson Allen, Jr., Milledgeville—Reference Committee No. 3.

Councilor Seventh District Report—D. Lloyd Wood, Dalton—Reference Committee No. 4.

Councilor Eighth District Report with Addendum—Neal F. Yeomans, Waycross—Reference Committee No. 4.

Councilor Ninth District Report—W. Bruce Schaefer, Toccoa—Reference Committee No. 5.

Councilor Tenth District Report—H. L. Cheves, Union Point—Reference Committee No. 5.

Vice-Councilor Third District Report—Guy J. Dillard, Columbus—Reference Committee No. 4.

No Report from First, Second, Fourth, Fifth, Sixth, Seventh, Eighth, Ninth and Tenth District Vice-Councilors.

Report of Council—H. L. Cheves, Chairman, Union Point—Reference Committee No. 1.

Report of Committee on Scientific Work—H. Ansley Seaman, Chairman, Waycross—Reference Committee No. 5.

Report of Committee on Legislation—Carl C. Aven, Chairman, Atlanta—Reference Committee No. 3.

Report of Committee on Medical Education—R. Hugh Wood, Chairman, Atlanta—Reference Committee No. 3.

Report with Addendum of Committee on Medical Defense—Marion C. Pruitt, Chairman, Atlanta—Reference Committee No. 4.

Report of Committee on Professional Conduct—Ralph H. Chaney, Chairman, Augusta—Reference Committee No. 1.

Report of Committee on History and Vital Statistics—J. Calvin Weaver, Chairman, Atlanta—Reference Committee No. 5.

Report of Committee on Public Health—T. A. Sappington, Chairman, Thomaston—Reference Committee No. 3.

Report of Committee on Maternal and Infant Welfare—Peter Hydrick, Chairman, College Park—Reference Committee No. 2.

Report with Addendum of Committee on Rural Health—W. W. Turner, Chairman, Nashville—Reference Committee No. 5.

Report of Committee on Industrial Health—Duncan Shepard, Chairman, Atlanta—Reference Committee No. 1.

Report of Committee on Public Relations—Chris J. McLoughlin, Chairman, Atlanta—Reference Committee No. 3.

Report of Committee on Cancer—J. E. Scarborough, Chairman, Atlanta—Reference Committee No. 4.

Report with Addendum of Insurance Board—John L. Elliott, Chairman, Savannah—Reference Committee No. 5.

Report with Addendum of Committee on Hospitals—R. J. Spanjer, Chairman, Cedartown—Reference Committee No. 2.

Report of Committee on Constitution and By-Laws—Allen H. Bunce, Chairman, Atlanta—Reference Committee No. 4.

Report of Advisory Committee to the Woman's Auxiliary—Ralph H. Chaney, Chairman, Augusta—Reference Committee No. 3.

Report of Committee on Awards—Mark S. Dougherty, Chairman, Atlanta—Reference Committee No. 1.

Report with Addendum of American Medical Education Foundation—E. Van Buren, Chairman, Atlanta—Reference Committee No. 5.

Report of Committee on Blood Banks—J. C. Thoroughman, Chairman, Atlanta—Reference Committee No. 3.

Report with Addendum of Abner Wellborn Calhoun Lectureship Committee—Glenville Giddings, Chairman, Atlanta—Reference Committee No. 4.

Report of Medical Civil Preparedness Committee—E. M. Dunstan, Chairman, Atlanta—Reference Committee No. 1.

Report of Veterans' Affairs Committee—Hartwell Joiner, Chairman, Gainesville—Reference Committee No. 2.

Report of Chronic Illness Committee—L. Minor Blackford, Chairman, Atlanta—Reference Committee No. 3.

Report of Liaison Advisory Board to the Georgia Society for Crippled Children—H. Walker Jernigan, Chairman, Atlanta—Reference Committee No. 4.

Report of Medical Advisory to Selective Service System Committee—A. O. Linch, Chairman, Atlanta—Reference Committee No. 1.

Report with Addendum of Crawford W. Long Memorial Committee—Lester Rumble, Jr., Chairman, Atlanta—Reference Committee No. 2.

Report of Mental Health Committee—J. R. Shannon Mays, Chairman, Macon—Reference Committee No. 3.

Report with Addendum of Advisory Board to the Clarke-Oconee County Study—Mark S. Dougherty, Jr., Chairman, Atlanta—Reference Committee No. 4.

Report of Honorary Advisory Board—C. F. Holton, Chairman, Savannah—Reference Committee No. 1.

Report of State Board of Health—R. Lee Rogers, Chairman, Gainesville—Reference Committee No. 2.

Report of State Board of Medical Examiners—Alex B. Russell, Chairman, Winder—Reference Committee No. 3.

Report of State Medical Education Board—C. L. Howard, Chairman, Pelham—Reference Committee No. 4.

Report of AMA Delegates—Charles H. Richardson, Sr., Macon, and Eustace A. Allen, Atlanta—Reference Committee No. 1.

Report of the JOURNAL: Editor, Associate Editor and Managing Editor David Henry Poer, Edgar Woody, Jr., and Mr. John F. Kiser, Atlanta—Reference Committee No. 2.

Report of Executive Secretary: Mr. Milton D. Krueger, Atlanta—Reference Committee No. 3.

No unfinished business was presented at this Session of the House of Delegates.

New business introduced at this session of the House of Delegates included the following resolutions.

Resolution on Anesthetic Study Commission introduced by Duncan SheparG, Atlanta, for Lester Rumble, Jr., Atlanta—Reference Committee No. 2.

Resolution on retiring MAG President introduced by Fred Simonton, Chickamauga—Reference Committee No. 1.

Resolution on Speaker of the House of Delegates introduced by Fred Simonton, Chickamauga—Reference Committee No. 2.

Resolution on Hospital Accreditation introduced by Fred Simonton, Chickamauga—Reference Committee No. 3.

Resolution on Professional Conduct and Ethics introduced by Herbert Alden, Atlanta—Reference Committee No. 4.

Resolution on History and Vital Statistics Committee introduced by Jack Norris, Atlanta—Reference Committee No. 5.

Resolution on Narcotic Prescriptions introduced by John Turner, Atlanta—Reference Committee No. 2.

Resolution on Veterans' Affairs introduced by Milford B. Hatcher, Macon—Reference Committee No. 2.

Resolution on Fluoridation of Water introduced by John Turner, Atlanta—Reference Committee No. 3.

At this time H. L. Pearson, AMA Judicial Council member, Miami, Florida, delivered a talk on "Activities of the AMA Judicial Council". This talk was followed by an address by Walter B. Martin, AMA President-Elect, Norfolk, Virginia, on "Legislative Activities of the AMA."

Report of the Woman's Auxiliary—Mrs. Leo Smith, Auxiliary President, Waycross—Reference Committee No. 4.

Report of the Better Health Council—Mrs. Bruce Schaefer, Acting Chairman, Toccoa—Reference Committee No. 5.

Report of the Georgia Nutrition Council—Guy V. Rice, Chairman, Atlanta—Reference Committee No. 5.

Speaker Goodwin recessed this session of the House of Delegates after the motion was duly made and seconded.

All activities and meetings other than those concerned specifically with Association business may be found in the program of the 104th Annual Session, Macon, May 2-5 which was published in the April, 1954, issue of the JMAG.

General Session

MONDAY, MAY 3, 1954

The General Session was called to order by President William Harbin, Rome at 10:45 a.m. At 12:30 President Harbin announced the Tellers Committee and voting rules. The Tellers Committee was composed of Charles Richardson, Sr., Chairman, Macon; Enoch Callaway, LaGrange, and W. F. Reavis, Waycross. Richardson announced the voting rules and hours and after some discussion it was generally agreed that voting hours would be 10:30 until 6 p.m. Harbin then called for nominations of officers.

PRESIDENT-ELECT—H. Dawson Allen, Milledgeville, nominated by M. Hines Roberts, Atlanta. Seconded by Rudolph Bell, Thomasville; J. G. McDaniel, Atlanta; Leo Smith, Waycross.

FIRST VICE-PRESIDENT—Willard R. Golsan, Macon, nominated by Charles Wasden, Macon. Seconded by W. F. Reavis, Waycross.

SECOND VICE-PRESIDENT—Milford B. Hatcher, Macon, nominated by Eustace A. Allen, Atlanta. Seconded by Charles Wall, Thomasville.

SECRETARY-TREASURER—Hugh Hailey, Atlanta, nominated by A. O. Linch, Atlanta. Seconded by A. M. Phillips, Macon; Harold P. McDonald, Atlanta; Jack C. Norris, Atlanta.

David Henry Poer, Atlanta, nominated by Lester Rumble, Jr., Atlanta. Seconded by H. L. Cheves, Union Point; C. F. Holton, Savannah; Ralph Chaney, Augusta; Fred Simonton, Chickamauga.

AMA DELEGATE—(Term beginning January 1, 1955)—Eustace A. Allen, Atlanta, nominated by H. L. Cheves, Union Point. Seconded by W. L. Shackelford, Atlanta, and T. A. Sappington, Thomaston.

AMA ALTERNATE DELEGATE—(Term beginning January 1, 1955) William R. Dancy, Savannah, nominated by

Ralph Chaney, Augusta; seconded by John Turner, Atlanta; T. A. Peterson, Savannah; and John L. Elliott, Savannah.

AMA DELEGATE—(Term beginning January 1, 1955)—Spencer Kirkland, Atlanta, nominated by Grady Coker, Canton, seconded by Jack C. Norris, Atlanta.

W. L. Pomeroy, Waycross, nominated by H. Ansley Seaman, Waycross, seconded by George H. Alexander, Forsyth; Sage Harper, Douglas; D. B. Terry, Homerville.

George M. Hutto, Columbus, nominated by W. G. Elliott, Cuthbert, seconded by W. K. Jordon, Macon, and A. B. Conger, Jr., Columbus.

George Dillinger, Thomasville, nominated by Charles Wall, Thomasville, seconded by T. A. Peterson, Savannah.

AMA ALTERNATE DELEGATE—Term beginning January 1, 1955)—Henry H. Tift, Macon nominated by W. G. Elliott, Cuthbert, seconded by George H. Alexander, Forsyth.

COUNCILOR NINTH DISTRICT—Bruce Schaefer, Toccoa, nominated by J. C. Norris, Atlanta, seconded by C. F. Holton, Savannah.

VICE-COUNCILOR NINTH DISTRICT—Charles Andrews, Canton, nominated by Jack C. Norris, Atlanta, and duly seconded.

COUNCILOR TENTH DISTRICT—H. L. Cheves, Union Point, nominated by J. B. Kay, Byron, and duly seconded.

VICE-COUNCILOR TENTH DISTRICT—J. Victor Roule, Augusta, nominated by Jack C. Norris, Atlanta, and duly seconded.

President Harbin then made some announcements concerning the meetings of the Scientific Sessions and there being no further business upon motion duly made and seconded the general session was adjourned.

Second Session, House of Delegates

(RECESSED)

TUESDAY, MAY 4, 1954

The House of Delegates was called to order by Speaker Goodwin at 2 p.m. in the Civic Room, Downstairs Auditorium, Macon.

Upon motion duly made and seconded Credentials Committee Chairman Henry H. Tift accepted the official Delegates attendance slips in lieu of a roll call as an official attendance record and reported a quorum present.

Attendance

Eustace A. Allen, Atlanta; H. Dawson Allen, Milledgeville; Charles R. Andrews, Jr., Canton; M. F. Arnold, Hawkinsville; J. J. Arrendale, Cornelia; C. C. Aven, Atlanta; C. L. Ayers, Toccoa; Guy Ayers, Jr., Atlanta; Rupert H. Bramblett, Cumming; J. B. Brown, Baxley; Stephen T. Brown, Atlanta; Allen H. Bunce, Atlanta; T. J. Busey, Fayetteville; Enoch Callaway, LaGrange; H. G. Carter, Decatur; J. W. Chambers, LaGrange; H. L. Cheves, Union Point; T. Sterling Claiborne, Atlanta; Remer Y. Clark, Marietta; Grady N. Coker, Canton; A. B. Conger, Jr., Columbus; C. T. Cowart, LaGrange; Ralph Davis, Rome; Hal M. Davison, Atlanta; George R. Dillinger, Thomasville; Mark S. Dougherty, Atlanta; F. G. Eldridge, Valdosta; John L. Elliott, Savannah; W. G. Elliott, Cuthbert; Ralph W. Fowler, Marietta; Charles B. Fulghum, Milledgeville; Thomas Goodwin, Augusta; J. A. Green, Athens; Marvin L. Greene, Jasper; E. M. Griffin, Bainbridge; Hugh Hailey, Atlanta; William Harbin, Rome; Sage Harper, Douglas; Milford B. Hatcher, Macon; Irvin D. Hellenga, Toccoa; B. L. Helton, Sandersville; J. H. Hilsman, Atlanta; C. F. Holton, Savannah; Lee Howard, Savannah; Lee Howard, Jr., Savannah; M. A. Hubert, Athens; G. M. Hutto, Columbus; Walker Jernigan, Atlanta; Alex P. Jones, Griffin; James B. Kay, Byron; Ruskin King, Savannah; Lewis R. Lang, Calhoun; A. G. LeRoy, Thomson; A. G. Little, Valdosta; R. B. Martin, Cuthbert; J. G. McDaniel, Atlanta; Harold P. McDonald, Atlanta; Earl T. McGhee, Dalton; Chris J. McLoughlin, Atlanta; W. A. Mendenhall, Chamblee; Joseph B. Mercer, Brunswick; W. C. Mitchell, Marietta; John Mooney, Statesboro; Charles Mulherin, Augusta; A. P. Mulkey, Millen; W. L. Osteen, Savannah; Clarence B. Palmer, Covington; Sam. E. Patton, Macon; A. M. Phillips, Macon; W. L. Pomeroy, Waycross; W. J. Revell, Louisville; W. P. Rhyne, Albany; A. C. Richardson, Atlanta; Thomas L. Ross, Jr., Macon; Alex B. Russell, Winder; T. A. Sappington, Thomaston; W. Bruce Schaefer, Toccoa; Glenn Seymour, Albany; B. L. Shackleford, Atlanta; Duncan Shepard, Atlanta; Kirk Shepard, Thomasville; Fred H. Simonton, Chickamauga; Leo Smith, Waycross; R. F. Spanjer, Cedartown; W. P. Stoner, Sylvester; David R. Thomas, Augusta; D. N. Thompson, Elberton; Henry H. Tift, Macon; John W. Turner, Atlanta; Robert Vaughn, Columbus; P. L. Williams, Sr., Cordele; George W. Wright, Augusta; Neal F. Yeomans, Waycross.

Speaker Goodwin called on President-Elect Peter B. Wright to introduce guest speaker Mr. Roy V. Harris, Augusta. Mr. Harris addressed the House of Delegates on legislative matters concerning the physicians of Georgia and accepted the position of Legal Advisor to the MAG Legislative Committee.

Speaker Goodwin appointed Allen H. Bunce parliamentarian for this session of the House of Delegates.

Speaker Goodwin then called for the reports of the chairmen of reference committees.

REPORT OF REFERENCE COMMITTEE NO. 1

C. F. Holton, Chairman

The following reports as presented to this Committee are printed in full with the Reference Committee's recommendation and the action pursuant to it by the House of Delegates.

President's Report

William Harbin

During this year the Medical Association of Georgia has continued to make progress in its organizational activities. While we have reason to be happy about many of our accomplishments, certain of our endeavors have fallen short of their expected goals.

The editor of the *Journal* and his associates deserve much praise for this year's publication and the national recognition of excellence which has been theirs. The format has been attractive, the scientific articles have been of the highest quality, and the general information about the Association's activities has been presented in an excellent manner.

Your President has attended many of the District and County Society meetings, in addition to the annual session of the American Medical Association. I have been favorably impressed with what has been done throughout the state and particularly with the interest that has been shown towards improving our public relations. A much closer relationship between the personnel in the central office and the county societies is highly desirable and to facilitate this, the executive secretary is making plans to attend the meetings of such societies and discuss the important objectives of organized medicine in which local cooperation is essential.

Many groups throughout the state have called upon your Association for advice and help, necessitating innumerable conferences during the year. I have acted as your representative to the best of my ability. The public has the highest regard for medical leadership in all matters pertaining to health and there are many reasons why this assignment must be willingly accepted by our profession.

We have again passed the two thousand membership mark in the American Medical Association and have regained a third delegate to the American Medical Association.

It has been a distinct pleasure to work with the President of the Woman's Auxiliary and under her guidance your Auxiliary has done an excellent job.

Recommendations have been made to the Constitution and By-Laws Committee and the majority of

these are included in the report of this committee. Although these are steps in the right direction I am convinced that plans should be made to completely overhaul and bring up to date this basic part of our organizational structure. This will be a Herculean, time-consuming task.

Most of the committees have performed in an excellent manner and on behalf of the Association I want to express our appreciation to these committee chairmen and their members. Much has been accomplished by the following—Public Relations, Veterans' Affairs, Maternal Welfare, Legislation, Public Health, Rural Health, Industrial Health, Scientific Work, Awards, Constitution and By-Laws, Blood Bank, Medical Civil Preparedness, Hospitals, and the Crawford W. Long Memorial. A detailed account of what they have done will be found in their respective reports.

Although there has been an increase in the individual contributions of members to the American Medical Education Foundation, the amount is still small and insignificant. We are accepting much help from other states for our medical schools when we are financially able to carry this load. A much larger percentage of the physicians in Georgia should give generously.

Much still remains to be done to help all Georgians obtain insurance to cover the major part of the cost of their medical and hospital care. Changes in the Georgia Plan which will encourage physicians to support it have not been put into effect, even after much hard work on the part of the Insurance Board. Acting through this Board, we should approve all Blue Shield Plans operating within the state and we should make constructive suggestions to co-ordinate such plans to make state-wide coverage available. We should encourage all voluntary health insurance plans and use our influence toward seeing that competition is fair and clean.

The Association has been very fortunate in having capable personnel in the central office. In order to retain desirable employees and give them the feeling of security they need in their employment, it is necessary for the council to make all decisions regarding their employment. Between meetings of the Council and its executive committee, the secretary should continue to have the authority to operate the office.

Many of the things which we set out to do require many years before they can be accomplished and for this reason the advice of the Honorary Advisory Board is essential. It is recommended that this board participate actively in the affairs of the Association. A pleasant and cooperative working relationship has existed with the immediate past president and the president-elect. This has been a source of deep satisfaction. I am grateful for having had the opportunity of serving as your president during this year.

Reference Committee recommendation—Sterling Claiborne, Atlanta, moved adoption without changes and it was so voted.

House of Delegates action—recommended adoption of President's Report which was moved, seconded and adopted.

First District Councilor's Report

Lee Howard Sr.

The main event in the First District was the very well attended meeting in Statesboro last Spring. An oyster roast for members of Council was given in Savannah in October.

I think there was a fair increase in membership for most of the societies in the district. I attended all but one Council meeting during the year and this meeting was attended by the Vice Councilor in my stead.

First District Membership

	Members		Members	
	MAG	AMA	MAG	AMA
	Dec. 31, 1953		Dec. 31, 1952	
Bulloch-Candler Evans	19	15	22	17
Burke	10	9	10	9
Chatham	135	114	125	112
Emanuel	5	5	4	4
Jenkins	3	3	3	3
Montgomery	3	2	3	2
Screven	5	5	5	5
Tattnall	7	3	6	1
Toombs	7	7	9	7
Tri-Liberty-Long-McIntosh	2	2	2	2
Total	196	165	189	162

Reference Committee recommendation—R. F. Spanjer, Cedar-town, moved adoption and it was so voted.

House of Delegates action—recommended adoption of First District Councilor's Report which was moved, seconded and adopted.

Second District Councilor's Report

George R. Dillinger

The District Meetings of 1953 in Albany and Moultrie were well attended, and excellent scientific programs were presented.

The Auxiliary has been active throughout the District, and is doing excellent work in Public Relations.

The larger County Societies, notably Decatur-Seminole, Dougherty, Colquitt, Tift and Thomas, have been active during the year. No report has been received from the smaller societies.

Due to lethargy on the part of the local societies, and the antagonism of certain newspaper publishers, no public forums have been held in the second district.

County societies should report meetings and activities to the District Councilor.

Second District Membership

	Members		Members	
	MAG	AMA	MAG	AMA
	Dec. 31, 1953		Dec. 31, 1952	
Brooks	5	5	4	4
Colquitt	18	11	19	12
Decatur-Seminole	17	15	19	16
Dougherty	38	16	34	14
Grady	8	2	8	2
Mitchell	12	8	12	9
Thomas	33	27	32	23
Tift	15	8	11	5
Tri-Calhoun-Early-Miller	14	10	14	9
Worth	7	5	5	5
Total	167	107	158	99

Reference Committee recommendation—A. B. Conger, Jr., Columbus, moved adoption and it was so voted.

House of Delegates action—recommended adoption of Second District Councilor's Report which was moved, seconded and adopted.

Report of Council

H. L. Cheves, Chairman

The Council of the Medical Association of Georgia met quarterly as stipulated in the Constitution and By-Laws. Meetings were held on the following dates: June 14, 1953, Atlanta; October 18, 1953, Savannah; January 17, 1954, Rome. Members with 100 per cent attendance at these meetings were: William Harbin, Rome; Peter B. Wright, Augusta; David Henry Poer, Atlanta; George R. Dillinger, Thomasville; W. G. Elliott, Cuthbert; Mark S. Dougherty, Atlanta; H. Dawson Allen, Jr., Milledgeville; D. Lloyd Wood, Dalton; Neal F. Yeomans, Waycross; and H. L. Cheves, Union Point. Vice Councilors with 100 per cent attendance were: Charles T. Brown, Guyton, and James M. Hicks, Brunswick.

The Executive Committee of Council met on the following dates: August 26, 1953, Atlanta; November 8, 1953, Atlanta; and February 23, 1954, Atlanta.

As indicated from the above tabulation, attendance at Council meetings has been excellent for the year 1953-54. Agendas for Council meetings have grown and Council deliberation and resultant action has been lengthy at these meetings. All matters of Association business brought before Council has been scrupulously recorded in the following issues of the *Journal of the Medical Association of Georgia*: see July, 1953; September, 1953; November, 1953; December, 1953; February, 1954.

Items and action of special significance brought before Council in 1953-54 were: (1) "the amount of \$1,000.00, recommended by the House of Delegates, was authorized for payment to the Crawford W. Long Memorial Museum;" (2) recommendations concerning MAG Constitution and By-Laws; (3) 1954 Budget; (4) MAG 1954 Program; etc.

Recommendation: That a vote of appreciation be given each member of Council for his active participation in Association affairs.

Reference Committee recommendations—Sterling Claiborne, Atlanta, recommended adoption and requested a note of commendation be written for Councilors' excellent attendance at all council meetings. This was seconded and adopted.

House of Delegates action—recommended the adoption of the Report of Council and commended them on their year's activities. Moved, seconded and adopted.

Professional Conduct Committee Report

R. H. Chaney, Chairman

The Professional Conduct Committee is able to report that during the past year, no problem arose that could not be settled at County or District level.

Thus, save for an organization meeting at which arrangements were made to meet on the call of the Chairman, no meetings have been held.

Reference Committee recommendations—Sterling Claiborne, Atlanta, moved its adoption which was duly seconded.

House of Delegates action—recommended approval of the report of the Professional Conduct Committee which was moved and adopted.

Industrial Health Committee Report

Duncan Shepard, Chairman

On November 12, 1953, the House Sub-Committee on Industrial Relations of the State Legislature conducted a hearing relative to amending the state compensation laws with the view to increasing the maximum amount of expenditures on any one compensation injury to \$1,500.00. Our committee was represented at this hearing by Dr. Allen M. Collinsworth, of Atlanta, who presented the views of the Medical Association of Georgia. Two recommendations were made through Dr. Collinsworth to the Sub-Committee, first, that the legal maximum expenses on any one case be increased over the present limit of \$750.00; second, that the limit for medical services be divided into two parts, one to cover exclusively the payment of professional services, including physicians and nurses, the other part to cover payments of non-professional services, including hospitals, drugs, etc. At the conclusion of the hearings the House Sub-Committee took no action on the proposed legislation, but it is hoped that at the next session of the Legislature that some action will be forthcoming. A transcript of Dr. Collinsworth's testimony before the Sub-Committee is attached to this report.

The Medical Association of Georgia was represented at the Fourteenth Annual Congress on Industrial Health at its annual session in Louisville, Kentucky, February 23rd through the 25th, by Dr. Allen M. Collinsworth. Dr. Collinsworth made a very interesting report to the committee on the various phases of Industrial Health which were covered by the Congress. His report is submitted to become a part of the records of this committee.

The Committee on Industrial Health met in Atlanta on February 23rd, and we were pleased to have the President of the Medical Association of Georgia, Dr. William Harbin, at our meeting. Various problems relative to industrial health were discussed by the committee, and it was suggested that a sub-committee be appointed to act as liaison with the insurance companies which carry compensation insurance.

The committee wishes to make the following recommendations:

1. That a sub-committee be appointed and it be called the Sub-Committee on Compensation Insurance, and that this committee be composed of three members. The committee feels that no more than one member should be replaced each year, so that the committee will have continuity of action.
2. It is suggested that this committee cooperate with the Atlanta Casualty Insurance Claim Managers Council in an effort to settle any problems arising between doctors handling compensation cases and the companies who are the insurance carriers for these cases.
3. It is felt that such a committee would serve a vital function in promoting mutual understanding and improving the proper handling of industrial injuries.

Reference Committee recommendations—Sage Harper, Douglas, moved the adoption which was duly seconded.

House of Delegates action—recommended the adoption of the Report of the Industrial Health Committee which was moved and adopted.

Report of Committee on Awards

Mark S. Dougherty, Jr., Chairman
Hoke Wammock, Co-Chairman

The Committee on Awards wishes to make the following report and recommendation:

(1) We wish to make the Hardman Award to Doctor Daniel C. Elkin, who is retiring as Professor of Surgery at Emory University. Doctor Elkin has had a long and distinguished career as a medical teacher and has made notable contributions to medical science in the field of vascular surgery particularly. We feel that his work has been outstanding in this section of the country and it is with great pleasure that we make the Hardman Award to him for the year 1954.

(2) We recommend that Doctor James B. Kay of Byron, Georgia, be selected as the practitioner of the year in the State of Georgia and that a proper biography of his life be compiled for submission to the American Medical Association as Georgia's candidate for the national practitioner of the year.

(3) We have provided certificates for the first, second and third awards to be made for the best scientific exhibits presented at the annual meeting. We wish to encourage the doctors of Georgia to present scientific exhibits at the annual meeting as we feel that it adds to the scientific excellence of a medical meeting. It is a medium that Georgia doctors can use in presenting the work they are doing. We are expecting to have excellent scientific exhibits at the Macon meeting.

Reference Committee recommendations—It was so voted and duly seconded that this report be adopted with the statement that the committee heartily endorses the selection of these two doctors for the award.

House of Delegates action—recommended that the Report of the Committee on Awards be adopted as presented and the motion carried.

Report of Medical Civil Preparedness Committee

Edgar M. Dunstan, Chairman

This year again the work of the Committee was intimately connected with that of the Medical Services Branch of the State Civil Defense Health Services Division, which has been in operation since February 19, 1951. Our Committee is the main advisory group for this Branch. Full minutes of the activities of this Branch are in the official files.

Representatives of this Committee attended the regular monthly school sessions and other meetings of this Branch throughout the year and participated prominently in the following key activities:

1. Completing, publishing and distributing "Recommended Medical Services Plan for Major Natural Disasters and Mobilization Check-List".

2. Completing, publishing and distributing "Steps to Put This Plan into Effect".

3. Completing "Recommended Practice Run Operations for Major Disasters".

4. Completing "Recommended Manual for Georgia Hospitals in Civil Defense".

5. Setting up the first "Course in Training for Veterinarians in the Medical Aspects of Atomic Warfare".

6. Presenting a full report of the 1952-53 Committee Activities to a general meeting of the Annual Session of the Medical Association of Georgia. The last part of this paper was devoted to "Mobilization in Civil Defense—The Preservation of Our Priceless Heritage", and was reprinted in the November issue of *Georgia's Health* (distribution 12,000 to 15,000), along with "Steps to Put the Plan into Effect".

After five years of intensive labor, the Committee thus comes to the end of the planning phase of this vital work. The major concern now is to put the plans into effect with every physician in the state knowing exactly what his duties are in this connection. The Committee feels that its future duties should be henceforth primarily advisory in the technical phases of this work and that the Association itself, through its Executive Department, should assume the responsibility of implementing the plans throughout its membership.

Accordingly, it is recommended:

1. That a small Medical Civilian Preparedness Committee, constituted as at present, be continued as a technical advisory group to the State Civil Defense Health Services Division and to prepare special studies as may be requested by the House of Delegates, the Council and the Executive Officers of the Medical Association of Georgia.

2. That members of the Council of the Medical Association of Georgia assume administrative responsibilities in the Medical Service Branch of the Georgia Civil Defense Health Services Division, as coordinators for their respective districts, in implementing as soon as possible the Georgia Civil Defense Health Services Plan through its four stages of mobilization. In carrying out these urgently important duties it is felt that a mobilization status report should be a regular agenda item at every Council Meeting and that the Medical Civilian Preparedness Committee should be requested to give the Council frequent reports of technical developments in the medical aspects of civil defense so that each Council member can transmit this information to the physicians in the district for which he is responsible.

Reference Committee recommendations—approved recommendation with the exception of paragraph No. 2. After some discussion it was recommended that the Chairman of this Committee select a physician in each district as a representative of the Medical Association of Georgia to be appointed by the president and not delegate the responsibility to Councilors.

House of Delegates action—recommended that the report of the Committee on Medical Civil Preparedness be adopted as presented specifically by the Reference Committee. The motion carried.

Report of the Honorary Advisory Board

C. F. Holton, Chairman

An activation meeting of the Honorary Advisory Board was held at the Dempsey Hotel at 12:30 p.m., May 2. The meeting was called to order by the Acting Chairman, C. F. Holton, and Allen H. Bunce

was elected Secretary to the Board. The following Past Presidents were present: C. F. Holton, Allen H. Bunce, C. H. Richardson, W. F. Reavis, Enoch Callaway, Grady Coker, A. M. Phillips, Ralph Chaney and J. A. Redfearn.

The items and action taken were as follows:

1. Permanent records of the Association—The Association hitherto has been careless in keeping permanent records, and was asked to recommend a permanent storage section of the MAG office for records of the Association dating back to its conception.

It was moved and seconded that the Acting Chairman appoint a committee from the Board to look into the matter and make whatever helpful suggestions possible. The Chairman appointed Drs. Bunce, Coker and Callaway to the Committee.

2. Modern bookkeeping system—It is felt that our present bookkeeping system is outdated and has in no way come along with the recent progress of the MAG. It was felt that an office expert should be consulted to streamline office bookkeeping in regard to dues, membership, etc.

The Board feels that as this item concerns strictly business matters and that the Council has complete charge of the business of the Association that this matter was not a proper one for us to discuss but should be referred to Council for whatever action it desires to take.

3. Financial reserves—Dr. Poer wonders if these reserves are invested in the best way (a) U. S. Bonds versus bonds with higher interest rates, loans to medical students and young M.D.'s.

It was the consensus of opinion of the Honorary Advisory Board that our funds for the present at least would be invested as they now are.

4. State medical boards—Dr. Poer wants more active MAG participation in setting up the state medical boards: State Board of Medical Examiners, State Board of Health, State Board of Medical Education, new Talmadge Hospital Board, etc. Dr. Poer also believes that the Association should have a closer liaison with the Governor in regard to all medical matters.

This Board feels that the By-Laws of our Association should be amended so that the duly appointed Legislative Committee can have more authority in the formation of the various Boards mentioned.

5. Cooperation with the Governor on matters concerning the Milledgeville State Hospital and mental patients in Georgia, screening centers in Atlanta, Augusta and Americus, and the present shortage of TB facilities in the State—

It was moved and seconded that the Honorary Advisory Board offer its services to the Governor in an advisory capacity in any matter in which he may call upon us.

6. Health insurance program—It is suggested that the Board consider the health insurance program in Georgia and make such recommendations concerning the Blue Shield coverage versus the commercial insurance companies programs and the Georgia Plan. Specifically, should MAG members be bound as par-

ticipating physicians in the Georgia Plan to consider the income levels of patients, in making charges for surgical procedures, obstetrics and orthopedics, etc.

The Board recommended that this question be left in the hands of the Insurance Committee who should make recommendations concerning this matter through the House of Delegates.

7. VA program—Dr. Poer believes that the Board should make a statement of policy concerning the AMA program on the enlargement of VA medicine into the field of private practice.

It was moved and seconded that this Board notify the House of Delegates that it is in favor of the AMA program concerning this matter. It was also moved and seconded that this Board notify the House of Delegates of the Medical Association of Georgia that we approve the stand of the AMA in opposing extension of Social Security to physicians on a compulsory basis.

8. Professional conduct—Dr. Poer believes your Board must set an ethical guide for the MAG physicians concerning rebates (kickbacks), ownership of drugstores and medical supply stores and just where to draw the line for ethical practice by the doctor.

It was the opinion of the Board that this matter be left to the standing committee on Professional Conduct.

Following the discussion and action on various items mentioned above, Enoch Callaway was nominated and elected as Chairman of the Honorary Advisory Board for next year. A motion was also made, seconded and carried that the chairmanship of this Board automatically go to the five-year Past President or his successor in line thereof.

Reference Committee recommendation—Sage Harper moved its adoption and it was duly seconded.

House of Delegates action—recommended the Report of the Honorary Advisory Board be adopted and the motion carried.

Report of the Medical Advisory Committee to the Selective Service System

A. O. Linch, Chairman

In accordance with the plan for rotating the chairmanship of the Georgia State Advisory Committee, I took over the duties as chairman on January 20, 1953. The committee as a whole remained intact. The name of Dr. Homer E. Nash was recommended by the Atlanta Medical Society to serve as an additional member of the committee and his appointment was duly approved by the National Advisory Committee. It was felt that Dr. Nash would be a great help in considering the essentiality of Negro physicians.

The reorganization of the new local committees was completed early in the year. A committee of ten members was appointed in each of the ten districts and also for Macon, Augusta, Columbus and Savannah. The chairman of these committees are as follows:

1st District—Dr. J. C. Metts, Savannah, Ga.

2nd District—Dr. Kirk Shepard, Thomasville, Ga.

3rd District—Dr. J. H. Robinson, III, Americus, Ga.

4th District—Dr. J. W. Chambers, LaGrange, Ga.

5th District—Dr. Robert W. Candler, Atlanta, Ga.

6th District—Dr. John A. Bell, Jr., Dublin, Ga.

7th District—Dr. John M. McGehee, Cedartown, Ga.

8th District—Dr. T. J. Ferrell, Waycross, Ga.

9th District—Dr. Alex B. Russell, Winder, Ga.

10th District—Dr. M. C. Adair, Washington, Ga.

Macon—Dr. Willard R. Golsan, Macon, Ga.

Augusta—Dr. Chas. G. Henry, Augusta, Ga.

Columbus—Dr. Luther H. Wolff, Columbus, Ga.

Savannah—Dr. Laurence B. Dunn, Savannah, Ga.

An orientation meeting for the new committees was held in Atlanta on February 22, 1953, at the Academy of Medicine following a meeting of the Medical Association of Georgia.

During the first half of 1953, the committee was called on to furnish many recommendations as to the essentiality or availability of both Special Registrants and Reservists. Many of these recommendations concerned Special Registrants of Priority III since the local Selective Service boards were continuing with the classification of this group.

Public Law 84, 83rd Congress, amending the Universal Military Training and Service Act, went into effect July 1, 1953, and will continue in effect to July 1, 1955. An important provision of this law created a change regarding the Priority II group. Priority II men were those who had ninety days to twenty-one months of active duty, however under the new amendment Priority II now includes those with ninety days to *seventeen* months of active duty. Those men with over seventeen months active duty will now be in the Priority IV group.

In September, 1953, we were advised that the Armed Forces would not issue calls for physicians or veterinarians on the Selective Service System for the remainder of their fiscal year, through June 30, 1954. The local boards were directed to cancel outstanding orders for induction or for preinduction physical examinations, however, they were directed to continue classifying Special Registrants. At the same time, the Committee was directed to give advice and recommendations when called on, especially regarding residents, teachers and research workers, and also to watch the situations in the various communities, medical schools, hospitals, etc. in order to be prepared when calls are resumed.

The Committee has diligently continued its efforts this year to reduce the number of physicians of Priority I now deferred by their local boards in Class 2-A. Some progress has been made in this respect. As of January 1, 1953, the number of Priority I men in Class 2-A was 32; as of January 1, 1954, the number was 22. The Priority II men in Class 2-A as of January 1, 1953, were 19, while there were only 13 in this class as of January 1, 1954. Those who have accepted reserve commissions and are classified 1-D in these priorities have also decreased materially during the year.

The status of all Priority I physicians in the de-

ferred classification was investigated during the year and recommendations as to their essentiality made to the various local boards. Some of these men are engaged in essential activities where it is difficult to replace them, however others who have been recommended as available by the Committee have been retained in the deferred classification by the local boards. In several instances we have insisted that the cases be referred to the proper Appeal Boards for adjudication but without success. It is the opinion of the members of this Committee that the State Advisory Committee should have the authority to appeal in such cases.

We will continue to function as an Advisory Committee to the Selective Service System to the best of our scope and ability. Even though the crisis has abated and the need has waned, there is still a useful function to be performed by the committee. We feel that the information and knowledge gained by our experience should not be allowed to lapse but should be perpetuated.

According to the plan of rotation, Dr. Cyrus W. Strickler, Jr. became chairman on January 1, 1954. Dr. W. G. Hamm has been appointed to serve as co-chairman. Any suggestions from the Association which will improve the effectiveness and usefulness of the Committee will be welcomed.

Reference Committee recommendations—Sterling Claiborne, Atlanta moved its adoption and it was so voted.

House of Delegates action—recommended adoption of the Report of the Medical Advisory Committee to Selective Service and the motion carried.

A.M.A. Delegates Report

C. H. Richardson

Eustace A. Allen

Activities of the House of Delegates to the American Medical Association at the 102nd Annual meeting in New York City in June and the Seventh Annual clinical session at St. Louis in December of last year have been reported to you in your Medical Association of Georgia Journal. A more complete account has appeared in the Journal of the American Medical Association at various times. To repeat these reports at this meeting would be a waste of your time. Many subjects affecting both physicians and the public, ranging from social security to public relations were acted upon. Standardization of membership, rural health program, medical care of the veterans, osteopathy, intern training, medical education, hospital accreditation were a few of the many resolutions acted upon at these meetings.

At the June meeting, Dr. Walter B. Martin of Norfolk, Va.—one of your guest speakers—was elected President-elect of the A. M. A. He will be installed as president at the June '54 meeting in San Francisco. The meeting in New York City was the largest ever held in the history of the Association.

Your delegates attended all meetings of the House of Delegates at both sessions. One of your delegates—Richardson—served on the reference committee. Report of officers at the Annual Session in New York, your other delegate—Allen—was on the reference committee for Insurance and Medical Service

at the St. Louis meeting. Many resolutions were introduced by constituent societies, and a number of these same resolutions will become the future policies of American medicine.

As you know, the American Medical Association is a federation of component medical societies of all counties, states and territories of the United States. You are an integral part of the A. M. A. Your delegates are your representatives in the House of Delegates, which is the policy making body for the A. M. A. Your delegates are anxious and willing to carry your suggestions and constructive criticism to the governing body. These must be in the form of resolutions and must come through your county and state associations. In other words, your delegates cannot write or carry individual resolutions to the A. M. A., unless approved by your local association.

There are many outstanding issues today, which need our backing. An expression from doctors from the local societies will help the House of Delegates in forming an opinion. Resolutions on Rural Health, Medical Ethics, Care of the Veteran, Public Relations and Social Security are needed and will help to clarify these issues. Do you approve of more regional meetings sponsored by the A. M. A.? What subjects would you wish discussed? You are often asked to express your feelings to your Congressman on various legislative matters. We are asking you to express to your delegates, through your associations, your feelings on matters of importance to a better understanding of health, practice of medicine and any other subject for the improvement of medical care.

The 103rd Annual Session will be held in San Francisco June 21st through 25th 1954, and the next clinical session will be held in Miami, Fla., November 30th through December 3rd 1954. Make a date now to attend.

Reference Committee recommendation—Sterling Claiborne, Atlanta, moved the adoption of this report and it was so voted.

House of Delegates action—recommended the adoption of the Report of the AMA Delegates and the motion carried.

Resolution on Retiring President Introduced by Fred Simonton, Chickamauga

WHEREAS, the retiring president has served two years, one as President-Elect and one as President, and has much valuable information and knowledge about organized medicine and the problems of the Medical Association of Georgia and

WHEREAS, his services to the Medical Association are indispensable, therefore,

BE IT RESOLVED that the retiring president of the Medical Association be an ex-officio member of the council for a period of one year.

Reference Committee recommendation—Sterling Claiborne, Atlanta, moved that this matter be referred to the Committee on Constitution and By-Laws, inasmuch as said committee had already initiated such action and it was so voted.

House of Delegates action—recommended that the Resolution on Retiring President be referred to the Constitution and By-Laws Committee and this motion carried.

Chairman Holton moved for the adoption of the Report of Reference Committee No. 1 as a whole and the motion carried.

REPORT OF REFERENCE COMMITTEE NO. 2

A. M. Phillips, Chairman

The following reports as presented to this Committee are printed in full with the Reference Committee's recommendation and the action pursuant to it by the House of Delegates.

Report of the President-Elect

Peter B. Wright

The President-Elect attended all of the meetings of the Executive Committee of the Council as well as all of the meetings of the Council during the year from May 1953 to date.

He instituted a recommendation to the effect that the immediate Past President become a member of Council and serve on year after his office as President. This would give a man an opportunity to serve for three years in a capacity that would be of benefit to the Medical Association of Georgia. It was realized that the year as President-Elect was a year of learning, the year as President was one of action and the year following would be one of an advisory capacity. This individual should be of considerable help to the Association.

As many of the various District Meetings as possible were attended during the past year.

The annual Installation Meeting of the Fulton County Medical Society was attended at the Atlanta Athletic Club on January 7th.

Realizing that good committees were essential and that active chairmen were completely necessary your President-Elect has set about to organize his committees and their chairmen in due time. It is his intention not to change committees that are working and showing progress but also it is his intention to reorganize committees that are not properly functioning.

He is aware of the difficulties confronting the insurance committee and their difficulties in getting statewide agreement on voluntary pre-payment medical benefit plans. This is one of our most serious problems and is being given a great deal of attention by your President-Elect.

Realizing the need of better legal advice for the Legislative Committee the President-Elect has taken it upon himself to ask Mr. Roy Harris of Augusta to appear before the delegates in Macon Sunday afternoon, May 2nd, at the annual State Meeting. It is very evident that there must be closer ties between the Medical Association of Georgia and the State Government as well as the Board of Medical Examiners. It is hoped that in the future the Governor of Georgia will be consulted much more frequently and draw us closer to the Administrative Head of the State Government.

Each committee has been studied seriously and with few exceptions they are doing very good jobs and there will not be very many changes made amongst the committees. One or two will have to be revamped.

Your President-Elect is exerting every effort and will continue to exert every effort to make the

coming year one that the Medical Association of Georgia will be happy to remember.

Reference Committee recommendation—The Committee approved the Report of the President-Elect.

House of Delegates action—recommended the adoption of the Report of the President-Elect and the motion carried.

Second Vice-President's Report

Milford B. Hatcher

As Second Vice-President of the Medical Association of Georgia, I attended the Third District Medical Meeting which was held in Americus to represent our president, Dr. William Harbin, who was unable to attend.

I also attended the meeting of the council which was held in Savannah in November, and I made plans to attend the council meeting in Rome but due to an error was not notified of the date of this meeting. I attended the meeting concerning veterans' affairs and also legislation.

Addendum

With the feeling that a delegate is more valuable with experience and feeling, that a delegate should know that he will represent a society as a delegate to the Medical Association of Georgia for more than one year, it is recommended that members to the House of Delegates to the MAG be elected for a period of from three to five years and upon being elected agree to serve. If the delegate is unable to attend two sessions his place be considered vacated and he be replaced by his alternate or another selected by his society.

Reference Committee recommendation—the Committee approves the Second Vice-President's Report and addendum.

House of Delegates action—recommended the adoption of the Second Vice President's Report and addendum and the motion carried.

Third District Councilor's Report

W. G. Elliott

The Third District Medical Society has two meetings yearly. One was held in April, the guest of the Crisp and Sumter County Societies, jointly at Lake Blackshear, the Veterans Park on the Flint River between Cordele and Americus. The other meeting was held in Americus in November. Both meetings were well attended and very good programs were given.

There are eleven organized Societies in the Third District. Turner County Society had only one member last year and that member is dead now. The other physicians in Turner County have joined other Societies. The Crisp County Society has become much more active since the new hospital opened in Cordele. Ocmulgee Society has reorganized and is much more active than in the past years. Houston-Peach County Society has only two members, as several physicians from these counties belong to the Bibb County Society in Macon. The Randolph-Terrell County Society is more active and the meetings are being better attended. It is planned for the meetings to be held in the different towns in the territory involved. Heretofore all meetings have been held in Cuthbert. We hope to meet part of the time in Dawson and Richland and Lumpkin. The

Sumter County Society is very active and they have very good programs. The Muscogee County Society has started publishing a monthly bulletin that is very good. That Society has started having Medical forums in Columbus, aided by the newspaper, and the Russell County Society of Alabama. They have very good Society meetings monthly, and always have good outstanding programs.

There were 177 members of the Medical Association of Georgia from the Third District, December 31, 1953, and 169, December 31, 1952. There were 145 American Medical Association members from the Third District, December 31, 1953, and 142, December 31, 1952, showing a slight gain.

Third District Membership

Counties	Members		Members	
	Dec. 31, 1953		Dec. 31, 1952	
	MAG	AMA	MAG	AMA
Ben Hill	13	10	13	8
Crisp	12	10	12	10
Dooley	5	5	7	6
Houston-Peach	2	2	2	2
Macon	3	2	4	3
Muscogee	92	81	80	74
Ocmulgee	8	6	8	5
Randolph-Terrell	14	9	15	11
Sumter	20	16	19	18
Taylor	5	4	5	4
Turner	—	—	—	—
Wilcox	3	—	2	—
Total	177	145	169	142

Reference Committee recommendation—the Committee approved the report of the Third District Councilor.

House of Delegates action—recommended the adoption of the report of the Third District Councilor and the motion carried.

Fourth District Councilor's Report

J. W. Chambers

Fourth District Membership

Counties	Members		Members	
	Dec. 31, 1953		Dec. 31, 1952	
	MAG	AMA	MAG	AMA
Clayton-Fayette	6	3	6	4
Coweta	18	—	19	—
Henry	1	—	0	—
Lamar	5	4	6	6
Meriwether-Harris	18	11	15	11
Newton	10	8	8	7
Spalding	32	28	34	21
Troup	40	37	42	38
Upson	20	17	19	16
Total	150	108	149	103

Reference Committee recommendation—the Committee approved the report of the Fourth District Councilor.

House of Delegates action—recommended the adoption of the report of the Fourth District Councilor and the motion carried.

Maternal and Infant Welfare

Committee Report

Peter Hydrick, Chairman

A. Activities—Two formal Committee meetings were held, October 17, 1953 in Atlanta, and January 17, 1954 in Macon. With the exception of two

members absent at each meeting, attendance was complete, either in person or by virtue of a substitute.

Carried Over From 1952-53

1. The Committee name was changed to include "Infant", to imply recognition of the peri-natal period and for inclusion of the neonatal age group. One pediatrician was appointed to the Committee. Another pediatrician substituted at the October meeting, and accepted the Committee's invitation to attend the January meeting, together with the original pediatrician.

2. *Maternal Death Studies*—As suggested by the 1952-53 Committee methods of study in other states were reviewed.

3. *Stillbirths and Neonatal Death Studies*—There was continued interest in this infant welfare area, as instigated by the 1952-53 Committee.

Follow Through and New Steps Taken

1. *Maternal Death Studies*—The Committee recognizes its responsibility to take any necessary steps to improve the maternal death rate in our State, though the maternal mortality rate of the state has improved 75 per cent in the past 13 years it is the feeling of the Committee that we can make further improvements if we know the exact problems which exist.

In order to best learn as accurately as possible the factors which are responsible for each maternal death, the Committee reviewed the procedures in studies in other states and viewed favorably the North Carolina Plan. This plan is impersonal and includes mail investigation using "clear letters, short and of a friendly nature." All names are removed from each record as soon as complete information has been obtained for analysis on the Committee, in order to make it impersonal. When the record is complete and has been analyzed it is filed, together with the analysis of members with the identifying data removed. It becomes a part of the permanent file.

With good physician cooperation it is anticipated that the exact cause of death; the course of the patient's final illness, and the treatment received will be available for studies, as to whether the death was preventable or non-preventable. Each preventable death represents one of three specific factors, patient or family ignorance and/or neglect in seeking medical care, lack of available facilities for care of the patient's problem, or an error in technique and management. By combining the information obtained we hope soon to be able to make recommendations on a district and state-wide basis to improve our positions in relation to other states.

2. *Stillbirth and Neonatal Death Study*—The Committee recognized that the reduction in fetal loss in the United States and in Georgia has been made less dramatic than that of the maternal death rate. Potter feels that at least one half of the conceptions are lost as a direct consequence of some obstetric complication.

Therefore, the Committee feels that any efforts to reduce maternal mortality and to improve manage-

ment of the women surviving toxemia hemorrhagic complications and acute medical and surgical emergencies occurring in pregnancy should be reflected in reducing the fetal stillbirth and neonatal death rate.

With an eye to using information in this area, not only to reduce fetal and neonatal morbidity and mortality, but also as a sensitive index of improved maternal health, the Committee acted in an advisory capacity to the Georgia Department of Public Health in the revision of the fetal death (formerly stillbirth) certificate, and of the live birth certificate.

Both certificates now serve not only as fact finding material as to "who", "when", "where", but "how" in terms of the prenatal and intranatal experience of the mother and child. They are in such form as to allow mechanical tabulation, and can be of real value for physicians doing special research, as well as for purposes of the Committee studies, and for recommendations based on the studies.

It is believed that a nation-leading step was taken in the revision of the live birth certificates. (After experience and questions, further recommendations for clarification have been made by the Committee.)

3. *Appointment of Subcommittee*—For the purpose of keeping district and local medical society groups informed of their problems and progress in maternal and infant welfare, it was suggested by the Maternal and Infant Welfare Committee that a representative be appointed to be responsible for this district function. The subcommittee was appointed by President Harbin and each member has accepted, and been given appropriate information in terms of districts and counties in terms of rates and numbers. No more complete identifying information has been supplied as it was hoped that each district, and each county with the district would then take the responsibility to attend to matters needing action.

4. *Committee Membership*—Staggering of Committee membership by years was reviewed favorably by the Committee. The desire is for continuity and broadened understanding. It was hoped that chairmanship would hold a term of two years.

5. *Work with other MAG Committees*—As the year rolled by, it became obvious that correlation of this Committee's work with other committees could reinforce the work of each. This year the Public Health Committee, the Blood Bank Committee and the Hospital Committee were most outstanding Committee contacts. More are anticipated, such as the Cancer Detection and Prevention Committee.

6. *Post-graduate Refreshers in Maternal and Infant Welfare*—The Committee again endorsed the Saluda Seminar and the Tri-State Obstetrical Seminar held jointly by Georgia, Florida and South Carolina. It was voted that expenses be paid for a representative to the Tri-State Seminar.

7. *Contraception*—Committee has reviewed information for allowing additional materials to be recommended for local public health programs use in this area of activity, when it is approved as a part of the program by local medical society and by the local health department. Other suggestions were made which should be helpful.

8. *Sterilization*—Medical and legal implications were studied and reviewed. Certain situations arise where such seems to be indicated, and it was felt more knowledge of procedure was needed in order to protect the physician.

9. *Recognized Needs on Statewide Basis*—(a) Implementation of early adequate care for all abnormal obstetric cases even when the infant only is involved, as for example in RH negative problems where previous trouble has occurred.

(b) Midwife legislation—though each member of the 1953-54 Committee has not had the opportunity to review the Georgia produced Flaherty Award winning movie, "All My Babies," the midwife training film shown at the 1953 MAG meeting under sponsorship of the Medical Women's Auxiliary, the need for promotion of better midwifery practice was recognized.

B. *Recommendations for Action*

1. *Maternal Death Studies*—That the North Carolina Plan for study of maternal deaths be accepted. That the Committee be given power to act in order that district and statewide recommendations can be made based on information obtained.

2. *Subcommittee*—That present subcommittee be continued 1954-55 since they have been just recently appointed, and though they have been given some information, the secretary has so far been able to contact only one member in person. The Committee requested that each be contacted personally. They have never really had opportunity to function yet.

3. *Committee Membership*—That provisions for staggering of Committee membership to be set up in the way considered most workable by the Council. This would allow both for continuity and broadened understanding, and avoidance of stagnation. It is recommended that the Committee Chairmanship term be two years.

4. *Special Postgraduate Refreshers in Maternal and Infant Welfare*—That the Association again endorse the Saluda Seminar in North Carolina, the Tri-State Seminar sponsored jointly by South Carolina, Georgia and Florida Divisions of Maternal and Child Health, and until action, the Maternal Welfare Committees of South Carolina and Florida. It is recommended that expenses be paid for a Committee representative to report at the Daytona Beach meeting, the shorter of the two.

5. *Contraception*—Endorse a product containing P-diisobutylphenoxypropylpolyethoxyenol with ricinilolaic acid for use in the public health department programs in addition to products and procedures previously endorsed by the MAG.

6. *Midwife Legislation*—Endorse the continued attempts to pass a bill which will assist mothers and infants and the better midwives of the State in places where midwife delivery is still a necessity by making practice of unscrupulous midwives illegal, and subject to prosecution for misdemeanor. The health department is responsible for certification but at present withdrawal of certificate does not mean that it is illegal for this midwife to continue to practice. She is subject to no penalty.

7. *Budget*—\$500.00 requested for 1953-54 with

\$100.00 allocated for the delegate to Daytona Beach Tri-State Obstetric Seminar.

Reference Committee recommendation—the Committee approved the Report of the Maternal and Infant Welfare Committee with the recommendation that the budget remain the same as was set for last year.

House of Delegates action—recommended the adoption of the Maternal and Infant Welfare Committee Report with budget specification as stated in the reference committee report and the motion carried.

Hospitals Committee Report

R. F. Spanjer, Chairman

The Committee on Hospitals has been principally engaged in sponsoring two projects:

(1) Accreditation of all Georgia hospitals of twenty-five (25) or more beds by the Joint Commission on Accreditation of Hospitals. It is felt that the best possible patient care can be obtained now and in the future by encouraging hospitals voluntarily to meet and maintain the excellent standards set by this Commission. To implement this program members of the Hospital Committee have discussed it at meetings of the Georgia Hospital Association, Regional Hospital Councils, Hospital services Division of the State Department of Public Health, and the Committee on Improvement of Nursing Service of the Georgia State Nurses Association. Also, all unaccredited hospitals in Georgia were sent copies of an abbreviated exposition of the standards established by the Joint Commission, encouraging these hospitals to seek accreditation in the near future.

(2) The organization of a Georgia Joint Commission for the Improvement of the Care of the Patient. This Georgia chapter of the National Joint Commission of the same name is made up of representatives from the Medical Association of Georgia, Georgia Hospital Association, Georgia State Nurses Association and Georgia League for Nursing. This Joint Commission will meet periodically for the purpose of stimulating, implementing, assisting in, and sponsoring activities which will contribute to the care of the patient as may be mutually satisfactory to the appointing organizations. To achieve this objective, the Commission performs as a service agency to the parent organization. The active members from the Medical Association are H. D. Tyler, Thomaston, and R. F. Spanjer, Cedartown, the ex-officio members are William Harbin, Rome, and Mr. Milton Krueger.

Addendum

I would like to make one additional report: On April 7 this year, the first organizational meeting of the Georgia Joint Commission for the Improvement of the Care of the Patient was held. The appointing organization, the Medical Association of Georgia, has to approve the organizational structure of the Commission. The MAG will be asked to consider the rules and regulations of this Commission as they see fit.

Reference Committee recommendation—the report of the Hospitals Committee and addendum was approved by the Committee.

House of Delegates action—recommended that the Report of the Hospitals Committee and addendum be adopted and the motion carried.

Report of Veterans' Affairs Committee

Hartwell Joiner, Chairman

We have had no complaints, requests nor recommendations on administration of present policies.

The V. A. Affairs Committee has been engaged in principally one major activity, viz.: Working with and through the A.M.A. with the knowledge of M.A.G. president and Council, on the matter of V. A. care of veterans with non-service connected disabilities. The Chairman met in Chicago with chairmen from the other states on Sept. 1, 1953, to hear the story, receive instructions on what to do. Again, representatives from regional states met in Atlanta on Nov. 8, 1953 for further instructions and discussions, and then on Dec. 6, 1953, the committee met in Atlanta with men from the state.

Our plan:

1. Instruct key men in each district and larger cities who will in turn inform the individual doctors.
2. Immediately talk frankly and truthfully to all veterans organizations.
3. Go then to the public—

Special groups, as civic clubs, women's organizations, hospital groups, women's league of voters, etc.

Comments:

This is a long fight. We must be unselfish and truthful. We have no substitute or compromise, nor do we propose one. Let every effort be to maintain the principle of the freedom of the practice of medicine. We have the best medical services in the world, improving all the time, and they will continue to do so. So, the very opposite is true in those counties where anything less than this principle is in effect.

Reference Committee recommendation—the Committee approved the report of the VA Committee.

House of Delegates action—recommended the adoption of the Report of the VA Committee and the motion was carried.

Report of Special Committee on the Crawford W. Long Memorial

Lester Rumble, Jr., Chairman

The passing of Dr. F. K. Boland has brought sorrow to all of us. The members of this committee feel that his loss has delayed the beginning of the proposed memorial to Dr. C. W. Long by the time lost in our attempt to familiarize ourselves with the work that he had done.

At present the general plans for this memorial, a museum devoted to anesthesia and other phases of medicine, have been completed. These plans are not included in this report, but a copy of them will be made available to the reference committee for the perusal of anyone interested.

We have assurances that the Georgia Historical Commission will supply the funds necessary for the physical completion of the Memorial according to the plans. The Commission, however, wishes the Medical Association of Georgia to go on record as being willing to accept the responsibility of its administration on completion. This responsibility would

consist of furnishing custodial care for the museum.

Last year, the Medical Association of Georgia allotted the sum of \$1,000.00 for this purpose. It was requested by Dr. Boland and approved by Council that this sum be allotted each year for ten years, if the funds are available. This amount each year is the estimated expense that would be involved in the maintenance of the Memorial, and represents only a small fraction of the sum which will be allotted by the Historical Commission in establishing a memorial commensurate with the magnitude of Dr. Long's discovery.

The recommendations of the committee are as follows and we urge the House of Delegates to give them thorough consideration:

- (1) That the Medical Association of Georgia go on record as being willing to accept the responsibility for the maintenance of the C. W. Long Memorial upon its completion.
- (2) That this committee be changed from a special committee to a standing committee in order to provide a group who will be in constant touch with the progress of the Museum and who will therefore be better able to supervise its maintenance.
- (3) That the sum of \$1,000.00 be allotted again this year for the purpose of guaranteeing maintenance of the museum upon completion.

Resolution on Crawford W. Long Memorial

Lester Rumble, Jr.
Perry P. Volpitta
A. B. Boyd

WHEREAS, the Historical Commission of the State of Georgia has expressed its desire for the establishment of a memorial museum to Dr. Crawford W. Long on the site of his discovery of the anesthetic powers of ether; and

WHEREAS, the citizens of Jefferson, Georgia, and the Historical Commission have purchased the site for this museum and are willing to defray the cost of its construction; and

WHEREAS, both groups have enlisted the cooperation of this Association in the planning of this venture with intent that it shall come under the supervision of this body after its completion;

BE IT RESOLVED: (1) that the Medical Association of Georgia go on record as being willing to accept the responsibility for the maintenance of the memorial upon its completion;

(2) That this committee be changed from a special committee to a standing committee, in order to provide continued progress and care of the museum;

(3) That the sum of \$1,000.00 be allotted again this year, if funds are available, for the purpose of guaranteeing maintenance of the project upon completion.

Reference Committee recommendation—the Committee approved the report of the Special Committee on Crawford W. Long Memorial and Resolution with the exception of the third recommendation which asked that the sum of \$1,000 be allotted for the purpose of guaranteeing maintenance of the museum upon completion.

House of Delegates action—Motion made by George Dillinger to remove paragraph No. 1. Discussion ensued in which it was stated that paragraph No. 2 by itself would be rather meaningless. John Turner, Atlanta, Harold McDonald, Atlanta, and William Harbin, Rome, expressed viewpoints. Discussion ended with Hal Davison, Atlanta, making the motion that the Association approve the continued maintenance of the Memorial this year with the amount not to exceed \$1,000 a year. The motion was seconded and passed.

Report of State Board of Health

R. Lee Rogers, Chairman

Georgia public health workers redoubled efforts in 1953 to maintain needed public health services in the face of a \$615,000 cut in Federal Funds. These reductions occurred in cancer, mental health, typhus, venereal disease, and tuberculosis programs. These cuts, along with the six per cent reduction in state funds have resulted in necessary curtailment of vital services. Outlook for the fiscal year 1954-55 was no brighter financially, with an additional \$200,000 reduction for Georgia included in the Federal budget.

The Mass Healthtest program, which tested some one and one-half million people in the state since 1945 was a major activity curtailed due to reduction in funds. Test included a chest X-ray for tuberculosis, blood test for syphilis, and since 1950, blood sugar determination.

While 151 counties have budgeted positions for local health employees, many health departments are understaffed. Only 49 counties, representing 57 per cent of the population of Georgia, were headed by full-time commissioners of health, at the end of 1953.

Efforts continue to be exerted toward building the local health department as the basic service unit in public health. A proposed new financial plan is presently under study, with its aim more adequate financing of local programs and full staffing of local departments with qualified personnel.

The State Board of Health designated a Committee on Legislation to secure sponsorship in the Georgia General Assembly for five public health bills and to review and make recommendations on proposed legislation with public health implications. The public health bills dealing with *Vital Statistics*, *Tuberculosis Control*, and *Tourist Court Sanitary Control*, were enacted into law; while bills to Regulate the Practice of Midwifery and to amend the present Rabies Control Act were not acted upon during the 1953 Sessions. Regulations for the Tuberculosis Control and Tourist Court Laws are currently under preparation and will be presented for adoption by the State Board at the next meeting.

Gamma globulin as an immunizing agent against poliomyelitis was studied by Georgia physicians and health departments in cooperation with National agencies, with the following conclusions reached: gamma globulin is of questionable value as a mass immunization procedure if given before the peak of an epidemic and of no value if given after the peak; and no value can be shown in its use in prophylaxis of contacts. Gamma globulin will continue to be available for prophylaxis of measles and infectious hepatitis. Selected counties in Georgia may participate in a study of the National Polio Foundation

of the prophylactic value of Salk vaccine.

Under the Hill-Burton program during 1953, 12 hospital facilities were completed or expanded and eight public health centers were completed.

In 1953, 26 physicians located in towns with new hospitals.

Proposed reduction by Congress of present Hill-Burton program will retard needed construction or enlargement of hospitals at Albany, Columbus, Athens, Milledgeville and Rome, and of a number of public health centers.

The program for children with rheumatic fever and heart disease has been extended by the Health Department, working cooperatively with the Georgia Heart Association.

A new fetal death certificate has been established and the livebirth certificate improved, as a result of cooperative effort of the maternal care committee and the State Health Department. The Health Department has assisted in the development of a cooperative program between one of our largest hospitals and the local health departments for improved maternal and child care. A film developed by the Health Department to provide supervision of midwives received a national award as the outstanding documentary film produced last year.

The Industrial Health Council of Greater Atlanta was chartered in January 1953, a joint project of the Medical Association and the Health Department; management; and labor.

Home accidents rank seventh among leading causes of death in Georgia. The Health Department, aided by a Kellogg grant, has launched a state-wide home safety program. Focus will be on stimulation of local home accident prevention programs.

Typhus fever cases increased 28 per cent in 1953 over the number of reported cases for 1952. From 1945 to 1952 cases were reduced from 1,111 to an all-time low of 32. Federal funds for state typhus control programs were drastically cut in 1953.

Fluoridation of water supplies is in various stages of completion in a number of Georgia communities. A specific policy on fluoridation was promulgated by the State Health Department in 1953 as a guide to communities which desire to employ this approved preventive method. Fluoridation has been demonstrated to reduce tooth decay as much as 65 per cent.

There were no cases of disease in Georgia last year reported as attributable to public water supplies, in spite of increased industrial development in Georgia which aggravates the state's water-pollution problem. The State Health Department has enjoyed excellent cooperation of more than 400 municipal, institutional and industrial water supply managers in the state.

Recommendations

The State Board of Health urges the Medical Association of Georgia to lend its voice in protest of the trend toward the reduction of Federal Funds granted to states for carrying out a grass-roots public health program. Recent slashes in venereal disease funds for states, for example, has virtually eliminated any state or local control program, while funds remain

for Federal-level, Federally-controlled activity. We believe that disease can only be prevented or controlled through local and state public health activity, carried on with the guidance and sanction of local and state medical societies.

We should like to enlist the cooperative effort of the medical profession in seeking to identify the extent and cause of non-fatal home accidents, in addition to their active participation in local home accident prevention programs.

A reaffirmation of the Medical Association's approval of fluoridation of water supplies as a safe and effective method of reducing dental caries would be of inestimable value to the State Health Department in its endeavor to encourage more and more Georgia cities to adopt a fluoridation program.

It is believed that laws to regulate the Practice of Midwifery and to strengthen the present Rabies Control Act are necessary, and it is planned that bills for these purposes will be introduced at the next session of the Georgia General Assembly. We hope that the members of the Medical Association will give their individual and organized support to these much needed health measures.

In summary, the State Board of Health invites the Medical Association of Georgia to visit the State Health Department and review its activities at any time, and hopes for a continued attitude of understanding and active participation in public health programs by the Medical Association members throughout the coming year.

Reference Committee recommendation—The Committee approved the Report of the State Board of Health and in addition requests in the future a detailed report of the work of the Industrial Health Council be submitted. Also, we recommend that a report be given to this Association from the Fulton County Medical Society regarding its attitude concerning the Council on Industrial Health.

House of Delegates action—recommended the Report of the State Board of Health be adopted and the motion carried.

REPORT OF THE JOURNAL

Report of the Editor of the Journal

David Henry Poer

In August, 1953 Dr. Edgar Woody joined the editorial staff of the *Journal* and along with Mr. John Kiser, the *Journal* has been published by these men. Assistance has been given by Mr. Milton Krueger and others but they deserve the lion's share of the credit for this highly complimented *Journal*.

On March 1, Miss Frances Porcher joined our staff as Editorial Assistant, taking over many of the duties of Mr. Kiser. At the last meeting of Council, the Executive Committee was set up as Publications Committee for the *Journal*.

Beginning March 1, the Editorial Board of the *Journal* was re-organized and will be made up of David Henry Poer, Edgar Woody, Mark Dougherty, Mr. Milton Krueger, and Mr. John Kiser. Details of the activity of the *Journal* will be presented by Dr. Woody and Mr. Kiser.

Reference Committee recommendation—The Report of the *Journal* was approved by the Committee.

House of Delegates action—recommended the adoption of the report of the *Journal*.

Report of the Associate and Managing Editors

Edgar Woody, Jr., and Mr. John F. Kiser

Staff and Policy

This yearly report on the current status of the *Journal* of the Medical Association of Georgia includes four primary topics concerning the program and policies of the *Journal* staff: staff and policy, content, typography and format and financial status. The publication has been changed considerably within the past year. The Editor and his associates submit the following report.

In order to facilitate final decisions regarding *Journal* policy, a recommendation was made at the last meeting of Council that the Executive Committee of Council act as Publications Committee of the *Journal*. It was felt that many decisions involving advertising, editorial policy and the like could be handled more quickly and easily through such a committee.

The Editors of the special sections of the *Journal*—J. Willis Hurst, Ted F. Leigh, and Arthur P. Richardson—have done an excellent job in their respective areas.

Geographic distribution of Contributing Editors has worked out quite well but reappointment on a yearly basis is considered essential for maximum productivity of all.

There has been considerable change within the headquarters staff. In September Mr. Krueger was succeeded as managing editor by Mr. Kiser. On March 1, Miss Porcher joined the staff as editorial assistant.

A policy of inviting guest editors has been instituted for special issues of the *Journal*. It is anticipated that several issues in the coming year will be under the direction of other guest editors.

Within the past six months the *Journal* has been published on an average of eight days earlier in each month.

The Editorial staff is practicing more strict adherence to specifications for scientific articles as regards maximum length, inclusion of references and use of illustrations.

Recommendations: that Contributing Editors be appointed on yearly basis and that the Executive Committee of Council act as Publications Committee of the *Journal*.

Content

During the past year a monthly Executive Secretary's Letter has been instituted. Its purpose is to keep doctors informed of medical and legislative activity on both state and national levels. It is written in crisp telegraphic style and is intended to impart up to the minute information not usually available from other sources.

The Georgia Heart Association is sponsoring a monthly page devoted to the clinical management of frequently encountered cardiac conditions. Controversial issues have been avoided, and a lucid straightforward resume of current thinking is published each month and beamed primarily at the general practitioner.

A section devoted to abstracts of papers by Georgia authors published outside the state has been added. Authors are contacted and asked to contribute their own abstracts. Their response has been excellent.

The Georgia Chapter of the American Cancer Society is supplying each month a timely paper on detection and/or treatment of cancer in its various phases.

More attention is given to publication of reports of Committees, dates and times of county society and district meetings. An effort is being made to give more thorough coverage to the organizational aspects of Georgia medicine.

Typography and Format

The striking changes brought about in the typography and format of the *Journal* in 1952-53, have been maintained during 1953-54. A few specific improvements in format made this year include:

More extensive use of bold face type; the use of larger text type and slightly smaller headline type; the use of more varied cover displays and more varied presentation of material in the magazine by distribution of feature pages in the back section of the *Journal* and by the addition of the Executive Secretary's Letter printed on yellow stock in the front section.

The *Journal* staff is particularly proud of its unusual cover illustrations which received considerable favorable comment at the State Journal Conference at A. M. A. headquarters in November. To augment the unique cover photographs by Ted F. Leigh, color was used for the first time in the December issue and a drawing was displayed on the November cover. Dr. Leigh's surrealistic photograph, which appeared on the January cover, received wide comment and the photograph-drawing combination on the April cover was another first for the *Journal*.

Attempts will be made during the coming year to maintain a consistent overall format while at the same time continuing to make specific changes to keep the *Journal* one of the better looking medical publications.

Financial Status

The financial status of the *Journal* at present is consistent with the pattern set by the *Journal* during 1952-53. In the past several months, national as well as local advertising has shown a marked increase.

For the months of December, January and February, the *Journal* enjoyed a 19.9 per cent increase in national advertising. Six additional pages of national advertising by companies producing anesthesia equipment were added to the March issue which commemorated the discovery of ether anesthesia by Crawford W. Long.

During the year efforts have been made to make advertising revenue pay for monthly printing costs. Although certain special issues have exceeded current advertising receipts, other less pretentious issues have achieved the desired balance. Expensive numbers like the January Roster issue and the Annual Session issue can be made possible by the publication of several 64-page issues each year.

Net Income From The Journal

Period of Nine Months Ended December 31, 1953

INCOME	
Advertising	\$12,699.99
Subscriptions	9,131.66
<hr/>	
Total Income	\$21,831.65
EXPENSES	
Salaries	\$ 5,525.00
Publication expenses	14,861.15
<hr/>	
Net Income	\$ 1,445.50

Reference Committee recommendation—the Committee approved the Report of the Associate and Managing Editors.

House of Delegates action—recommended the adoption of the Report of the Associate and Managing Editors and the motion carried.

Resolution on Anesthetic Study Commission

Lester Rumble, Jr.

WHEREAS, the Section on Anesthesiology of the Medical Association of Georgia has expressed its desire for the establishment of a commission for the purpose of studying and analyzing the deaths which occur within 72 hours of anesthesia and surgery; and

WHEREAS, similar commissions are functioning in many localities throughout the United States and are proving their worth; and

WHEREAS, a plan has been devised to give the State Medical Association a properly organized and functional commission; and

WHEREAS, the approval of the association will aid and give impetus to the establishment of such a group,

BE IT RESOLVED, that the Medical Association of Georgia go on record as approving the principle of the Anesthetic Study Commission.

Reference Committee recommendation—the Committee recommends approval of the Anesthetic Study Commission as presented in a resolution by the Section on Anesthesiology.

House of Delegates action—recommended the adoption of the resolution on the Anesthetic Study Commission and the motion carried.

Resolution on Speaker of House of Delegates

Fred Simonton

WHEREAS, the speaker of the House of Delegates, by virtue of his office should know all the facts concerning the Medical Association and its activities, and

WHEREAS, the speaker and the House of Delegates actually run the Medical Association of Georgia, but have only one session during the calendar year and the council acts for the House of Delegates when they are not in session,

BE IT RESOLVED, that the Speaker of the House of Delegates be an ex-officio member of the Council.

Reference Committee recommendation—approval was given by the Committee of the resolution to make the speaker of the House of Delegates an ex-officio member of Council. It was also recommended that the speaker be elected for a period of two years.

House of Delegates action—Enoch Callaway, LaGrange, moved that this resolution be tabled after some discussion ensued. The motion was seconded and carried.

Resolution on Veterans Affairs

Milford Hatcher

The House of Delegates of the Medical Association of Georgia hereby instructs that the delegates of the Medical Association of Georgia to the American Medical Association present a resolution to the House of Delegates of the American Medical Association at its meeting in June, 1954, having to do with the treatment of Veterans who have non-service connected disabilities. This resolution shall include the following.

First, for immediate action, recommendations be made to change and improve existing legislation having to do with the medical and hospital care of non-service connected disabilities, in order that

(a) any veteran applying for admission to a Veterans Administration Hospital because of a non-service connected disability shall be admitted only after he has signed a sworn statement that he is medically indigent.

(b) adequate investigation of such sworn statements be made and in the event of fraud, such will be prosecuted by the United States government.

Second, that favorable consideration be given a plan whereby medically indigent veterans with non-service connected disabilities will be given medical and hospital care in their local communities, that a means test which is sound be used to determine such indigency, and that voluntary health insurance plans be used by the federal government to provide such medical and hospital care.

If in the opinion of the delegates, changes in the wording of this resolution are deemed necessary, such authority is granted, provided such changes do not alter the intent of this resolution.

Reference Committee recommendation—the Committee approves the Resolution on Veterans Affairs submitted by Milford Hatcher and recommends that appointment of a Committee headed by Allen Bunce to rewrite the resolution, retaining its original intent.

House of Delegates action—recommends this resolution be rewritten by Allen Bunce, Atlanta, retaining its original intent and approve that this be adopted, the motion carried.

Resolution on Dispensing of Narcotics

John W. Turner

The Delegates from the Fulton County Medical Society recommend to the House of Delegates and the Medical Association of Georgia, that

WHEREAS the present enforcement of the most stringent measures in regard to the dispensing of narcotic drugs, even those of low addiction such as Dover's Powder, etc., in prescriptions prevents the doctor from giving a prescription over the phone and later mailing it to the druggist,

WHEREAS, this demands that the patient either come into the doctor's office or the doctor go to see the patient, causing a great inconvenience and working a hardship on the doctor and on the patient, that

BE IT RESOLVED, that (1) the Medical Association of Georgia go on record as recommending a review of the Harrison Narcotic Act with the idea of removing from its supervision drugs of no addiction.

(2) That the Medical Association of Georgia go on record as approving House Bill No. HR 7817

endorsed by the American Medical Association for the relief of this hardship.

(3) That a copy of these resolutions mailed to our representatives in Congress requesting that they support this House Bill HR 7817.

Reference Committee recommendation—The Committee recommends that the House of Delegates approve the resolution on Dispensing of Narcotics as submitted by the Fulton County Medical Society.

House of Delegates action—recommended the adoption of the resolution on the Dispensing of Narcotics and the motion carried.

Chairman Phillips moved for the adoption of the Report of Reference Committee No. 2 as a whole and the motion carried.

REPORT OF REFERENCE COMMITTEE NO. 3

Fred Simonton, Chairman

The following reports as presented to this Committee are printed in full with the Reference Committee's recommendation and the action pursuant to it by the House of Delegates.

Fifth District Councilor's Report

Mark S. Dougherty, Jr.

The affairs of the Fifth District have moved along satisfactorily this year with the largest membership in the history of the Fulton and DeKalb County Medical Societies.

The Fifth District Medical Society met on November 5th at the Academy of Medicine with Doctor Frederick N. Silverman of Cincinnati, Ohio speaking on Urologic Problems in Pediatric X-Ray Diagnosis.

The DeKalb County Medical Society was visited on the 5th of April and we found their affairs in excellent condition.

A considerable amount of interest is being shown in the insurance program in the State and hope is expressed for a unified insurance program for the entire State.

There is also considerable interest being shown in contemplated legislation in the national congress which will provide some inclusion of the medical profession in the Social Security program on a voluntary basis.

The roster of the membership for the societies is attached. We hope that we can attain a higher percentage of American Medical Association membership in the members of the Medical Association of Georgia.

Fifth District Membership

Counties	Members Dec. 31, 1953		Members Dec. 31, 1952	
	MAG	AMA	MAG	AMA
DeKalb	37	31	30	30
Fulton	832	595	810	596
Rockdale	1	1	1	1
Total	870	627	841	627

Reference Committee recommendation—The Committee approved the report of the Councilor of the Fifth District and it was so voted.

House of Delegates action—recommended the adoption of the Councilor, Fifth District Report and the motion carried.

Sixth District Councilor's Report

H. D. Allen, Jr.

The Sixth District Society has held its two regular meetings, an April meeting in Dublin, Georgia, and the December meeting in Macon. Both meetings were well attended. A review of the membership of the District shows a gain of 20 members in the Medical Association of Georgia, the members being 206 for '53 as compared with 186 for '54. There was also a gain of two members in the AMA, 156 for 1953 compared to 154 in 1952. It is hoped that the councilors' efforts in writing each of the secretaries calling attention to doctors listed by the Secretary of State as in practice but not members of the Medical Association of Georgia may have helped in obtaining this increase in membership. These letters to each secretary disclosed that several of the doctors were not acceptable to membership and several have died. I am sorry I do not have a list of the life members in this district but am sure that a number have been voted life members and this makes the gain in membership more significant. One doctor whose professional conduct was under question changed residence and is no longer in the Sixth District. As far as known he was not a member of the county medical society and has made no effort to seek membership by transfer. This case was considered closed.

Sixth District Membership

Counties	Members Dec. 31, 1953		Members Dec. 31, 1952	
	MAG	AMA	MAG	AMA
Baldwin	28	11	27	10
Bibb	128	113	115	110
Hancock	3	1	3	1
Jasper	4	3	2	2
Jefferson	4	3	2	2
Laurens	19	11	24	13
Monroe	4	3	4	3
Washington	14	11	13	11
Total	206	156	186	154

Reference Committee recommendation—the Committee approves the report of the Sixth District Councilor and it was so voted.

House of Delegates action—recommended the adoption of the Sixth District Councilor's report and the motion carried.

Report of Committee on Legislation

Carl C. Aven, Chairman

Our Committee met with the members of the Georgia Society of Medical Technologists, and discussed the probability of adverse legislation being introduced on a state level that would effect the training of medical technologists. As said legislation was not introduced in the Georgia Legislature, the Committee took no action.

Our Committee met October 21, 1953, to discuss all legislative matters affecting physicians. In considering legislation for the Georgia Legislature, the following proposals were discussed: the Hospital Lien Bill with amendments to include the physician in insurance company payment; Osteopathic legislation, which after discussion was tabled pending clarification

of future AMA policy; discussed and approved the so-called "injunction bill" (giving further power to enjoin from the practice of medicine, unqualified personnel) which was introduced at a previous session of the Georgia Legislature, but never brought out of Committee; approved and contacted the Atlanta Better Business Bureau on certain unfavorable advertisements carried in publications in the State; approved various bills introduced in the Georgia Legislature such as Tuberculosis control, regulation of midwifery, regulation of tourist courts, rabies control act. Approved and supported the Industrial Surgeons proposed amendment to the Georgia Workmen's Compensation Act.

The Committee also met jointly on two occasions with the AMA Regional Legislative group and cooperated with AMA on the following national legislations: Supported the principle of the Bricker Amendment; supported and approved VA Medical and Hospital Care policies of the AMA and the MAG Veterans Affairs Committee; supported and approved an amendment to the Federal Narcotics Act concerning phone call and mail prescriptions; and supported and approved the Keogh-Jenkins-Reid omnibus tax bill concerning social security coverage as it affects physicians.

The Committee recommends the following:

1. That the ten (10) key men appointed to act over the State in furthering favorable legislation be retained, and that these men be chosen on a basis of one from each congressional district.
2. That the legislative Committee consider action concerning the amending and implementing of the Georgia Drug Act (sedatives, etc.).
3. That the "injunction bill" be shortened and reintroduced at the next session of the Georgia Legislature.
4. Support the inactment of the "Hospital Lien Law" at the next Session of the Georgia Legislature.
5. That a letter of appreciation be transmitted by the President of the Medical Association of Georgia to the Better Health Council for their cooperation in making available daily reports of legislative progress at the recent Georgia Legislature session; said reports which were furnished the MAG Legislative Committee during this session.

Reference Committee recommendation—The Committee approves the report of the Committee on Legislation and wishes to commend the Committee members for their fine work and it was so voted.

House of Delegates action—recommended the report of the Committee on Legislation be adopted and the motion carried.

Report of Committee on Medical Education

R. Hugh Wood, Chairman

No Report.

Reference Committee recommendation—The Committee recommends that the Committee on Medical Education submit a report of their year's work at the next Annual Session, as no report was received.

House of Delegates action—recommended that the motion by the Reference Committee pertaining to the submitting of a written report by the Committee on Medical Education be approved, and the motion carried.

Public Health Committee Report

T. A. Sappington, Chairman

The Committee on Public Health has met twice since this committee was appointed. A copy of the minutes of each meeting is given as the report of this committee.

It is felt that by an active Committee on Public Health a closer cooperation and understanding between the Medical Association of Georgia and the State Department of Public Health can be obtained.

Following are the minutes of the two committee meetings.

Attending a meeting of the Committee on Public Health, Medical Association of Georgia, at the office of the Director of the State Health Department, at 2:30 p.m., December 29, 1953, were the following: T. A. Sappington, Thomaston, Chairman; B. H. Hand, LaGrange; T. F. Sellers, Guy V. Rice, S. C. Rutland and David Henry Poer, all of Atlanta, and Mr. John F. Kiser, Assistant Executive Secretary, MAG headquarters.

After Dr. Sellers reviewed the activities of the various divisions of the department, the following action was taken:

1. Recommended closer cooperation between the medical profession and public health officials.
2. Recommended study of means by which medical profession and health department together can assist small communities in the construction of small health centers to be used by private physicians.
3. Received from Dr. Sellers, a report of planning in regard to the Salk polio vaccine field trial in Georgia, and a recommendation the MAG approve this plan.
4. Received a report from Dr. Sellers concerning the sponsorship and operation of the Eugene Talmadge Memorial Hospital, now under construction in Augusta.
5. Other topics discussed included: a sampling census of chronic disease in Georgia; reorganization of local health services, and the home accident prevention program made possible by a Kellogg Foundation grant.

Attending a Meeting of the MAG Public Health Subcommittee at 4:00 p.m., Thursday, January 7, 1954 at the Academy of Medicine were the following: T. A. Sappington, Thomaston, chairman; Evan W. Molyneaux, Hogansville; J. B. Neighbors, Athens; J. T. Holt, Baxley; J. M. Byne, Jr., Waynesboro; Sylvester Cain, Norcross; H. G. Lee, Millen; Ernest Thompson, Monroe; James R. Thomas, Griffin; J. Gregg Smith, Valdosta; O. H. Cheek, Dublin; C. J. Maloy, McRae; David M. Wolfe, Albany; H. L. Erwin, Dalton; F. O. Garrison, Demorest; and S. C. Rutland, T. F. Sellers, and Guy V. Rice, Atlanta.

The following action was taken:

1. Recommended that MAG Council approve plans for the Salk Polio Vaccine Field Trial in Georgia in February, 1954 to be administered by the Public Health Department and the National Foundation for Infantile Paralysis.
2. Recommended that MAG Council endorse the present policy of Public Health Department relative

to the allocation of state and federal funds to communities for the assistance in the construction of hospital and public health centers.

3. Recommended that MAG Council consider appropriate action concerning Resolution No. 16, introduced at the recent A.M.A. Clinical Session in St. Louis in regard to the Manion Commission.

4. Recommended closer cooperation between the medical profession and public health officials.

5. Received a report from Dr. Sellers concerning the successful transference of operation of the Eugene Talmadge Memorial Hospital from the State Board of Health to the Board of Regents.

Reference Committee recommendation—The Committee approves the report of the Committee on Public Health and it was so voted.

House of Delegates action—recommended the adoption of the report of the Public Health Committee and the motion carried.

Report of Public Relations Committee

C. J. McLoughlin, Chairman

During the past year the Public Relations Committee has sponsored and carried out a rather extensive program for acquainting the public with their doctors on a more friendly basis.

In September a meeting was held in Atlanta, to which representatives of various large counties and newspapers were invited for the purpose of discussing the use of public Forum as a means of good public relations. Almost one hundred per cent of those attending the meeting in September were very enthusiastic in their support. This resulted in a series of Forum being held this year in the following towns: Atlanta, Augusta, Athens, Savannah, Columbus, Macon, Griffin, and Rome. Most of these Forums were put on in cooperation with the local news agencies, thus providing better understanding between the physicians and their press representatives. These Forums were an outstanding success wherever they were made. One or two papers in towns where the Forums were *not* held wrote editorials asking the doctors to sponsor them.

In October, an exhibit was set up at the Southeastern States Fair. The theme of the exhibit was the recruitment of new personnel for paramedical fields. This included exhibits on the work of x-ray and laboratory technicians; recruitment of nurses; "Today's Health"; and featured an excellent exhibit of photographs entitled "Faces of the Hospital," prepared by Dr. Ted Leigh. An AMA display on "Fooling the Fat" was also a part of this State Fair exhibit. Dr. Leigh's exhibit is available for display in high schools and libraries throughout the state.

In November, the Public Relations Committee worked in conjunction with a group from the American Medical Association to sponsor a meeting for the Southeastern states to discuss Veterans Medical Care. In December, a meeting was held in conjunction with the Veterans Affairs Committee of the Medical Association of Georgia to discuss medical care among the veterans of Georgia.

A survey has been made of the counties throughout Georgia to try to establish Emergency Telephone

Call Service of one sort or another in all counties. We were quite pleased to find how many of the various societies already have these emergency call systems in operation.

A survey was also made on behalf of Physicians Placement Service to provide physicians for towns and counties where the need was determined.

A few small local news conferences were held under the auspices of the committee.

The fact that we were able to accomplish this much seems rather amazing, in view of the fact that we have been operating on a proverbial shoestring. An attempt was made to raise funds by establishing a 25-52 Club (members who were willing to donate 25c per week for 52 weeks for better public relations). This met with some success to the tune of about \$500 but this, plus the present appropriation, is but a drop in the bucket as compared to what we really need for a complete program.

By way of recommendations, we would like to suggest a continuation of the spirit of service manifested throughout the past year. We also consider it advisable to change the name of "Public Relations" to "Public Service"—for that is essentially what this committee represents.

Lastly, and by no means least, an adequate budget should be established. Public Relations is a very important item in the budget of every business organization throughout the country. Any organization with 2200 members should be run on a good sound business basis also. Many state medical societies with far less members than our own are investing from \$5 to \$50 per member in the Public Relations Committee. A lot has been accomplished, a lot is being done, much still remains to be done.

We appreciate greatly the cooperation we have had from every one and hope the coming year will bring even a greater success than the last.

Reference Committee recommendation—the Committee approves the report of the Committee on Public Relations and so voted.

House of Delegates action—recommended the adoption of the Report of the Public Relations Committee and the motion carried.

Report of the Advisory Committee To Woman's Auxiliary

R. H. Chaney, Chairman

The Advisory Committee to the Woman's Auxiliary met with the Executive Committee of the Auxiliary in Macon, Georgia, and considered their program for the current year and gave approval.

The value of the Auxiliary to the Association is attested by the report of its President and by their annual published report. There is no doubt that the Auxiliary is making strides in improving our Public Relations Problem and they should receive the thanks of the Association for their work.

Reference Committee recommendation—the Committee approved the report of the Advisory Committee to Woman's Auxiliary and so voted.

House of Delegates action—recommended that the report of the Advisory Committee to Woman's Auxiliary be adopted and the motion carried.

Report of Committee on Blood Banks

J. C. Thoroughman, Chairman

The Committee has held one formal meeting this year and several meetings by correspondence. Another meeting is scheduled to be held Sunday, May 2nd in Macon.

Blood Banks

The present committee has continued the work of last year's committee in compiling a list of blood banks throughout the state. In Georgia there are 214 hospitals varying in size from 3 to 10,000. The three Veterans Administration Hospitals have answered requests for information. Forty-three of these use blood drawn in the hospital, thirty-five use blood from the Red Cross, and thirteen use blood from other hospital blood banks. Twenty-three hospitals report more than 500 transfusions a year. The Red Cross collecting centers in Savannah and Atlanta are in addition to the above figures.

Liaison With Other Agencies

The committee has worked in close cooperation with the Committee on Blood and Blood Substitutes of the State Civil Defense Program and with the Division of Hospital Services of the Georgia Department of Public Health, and numerous unofficial conferences have been held with members of these agencies.

One of the duties of this committee has been to offer its services in attempting to promote better understanding between other organizations engaged in collecting blood in the state. On two occasions we have been called upon to act in this capacity.

Subcommittee on Minimal Standards for Blood Banks

For practical purposes it is necessary to adopt a definition of the term "Blood Bank" and also to suggest certain minimal standards for these blood banks, if blood from one collecting agency is to be used by other institutions. Your committee and the corresponding committee of the Civil Defense program has requested the following organizations to appoint a representative on such a committee:

Medical Association of Georgia
Georgia Association of Clinical Pathologists
Georgia Hospital Association
Georgia Department of Public Health
Georgia Civil Defense
American Red Cross
Georgia Society of Medical Technologists

These representatives were appointed, and this subcommittee is now working under its chairman, Dr. Darrell Ayers.

Civil Defense Aspects of the Blood Program

So far only 5,134 units of blood have been pledged to be supplied within 24 hours by hospitals and other agencies in the state in event of a civil or military disaster. This small amount would actually be less than the above figure inasmuch as the community involved in the disaster would be unable to furnish its quota. Plans for transportation and mobilization of this blood are yet to be worked out by the civil defense group. This is a matter of concern to the Medical Association of Georgia and its individual

members, and it is recommended that the study of this problem be continued during the coming year.

Educational

The committee realizes that although the plasma expanders have a definite role in the treatment of emergency conditions, transfusion of whole blood has a dominant role in both normal and emergency medical practice. The use of whole blood is not without certain dangers and we have encouraged preparations of articles dealing with these problems. Two articles are now being written.

At the request of the Georgia Society of Medical Technologists, certain members of the committee participated in a panel discussion on the technical and defense aspects of blood banks when the society held its annual meeting in Columbus in April.

We wish to express our appreciation for the assistance and encouragement given by the officers and office staff of the Medical Association of Georgia, and to the many others who have cooperated in the work of this past year.

Reference Committee recommendation—the Committee approves the report of the Committee on Blood Banks and so voted.

House of Delegates action—recommended the adoption of the report of the Committee on Blood Banks and the motion carried.

Report of Committee on Chronic Illness

L. Minor Blackford, Chairman

Unlike the weather, something is being done about chronic illness in Georgia. The problems involved are many, varied and tough, but some progress in their solution is being made.

These problems may be considered under two heads: those involving restoration of the patient to economic independence and those concerning the patient with a less promising outlook.

Rehabilitation

Rehabilitation may imply only simple measures that can be carried out in any hospital with a short convalescence. Since a man with a hernia cannot get a job in any company that requires a preliminary physical examination, hernia repair is the prime example of this type of rehabilitation.

But the rehabilitation of one patient may require the services of a number of specialists, physical therapists, occupational therapists, and social workers, for months or even years. Such conditions are exemplified in the paraplegia resulting from industrial accidents or car wrecks and in severe paralysis from poliomyelitis. It must be emphasized that the expenditure of even \$10,000 to convert a helpless young man with several children (and perhaps more in the offing) to a self-supporting tax-payer, aside from humanitarian satisfaction, is good economics. When an artificial leg is given an amputee without adequate training in its use, it is apt to wind up uselessly under the bed, and that is poor economics.

Georgia's Vocational Rehabilitation Service for several years has been the best, or one of the best, in the country. At the same time, it has to send a good many severely disabled patients to New York (at a cost in 1952 of about \$80,000) or Virginia for some types of therapy or training. This gripes the

patriotic souls of your Committee. Last year your Committee expressed the hope that a Vocational Rehabilitation Center would be set up in a Georgia center where specialists in every field would be available to meet the needs of this state, South Carolina, Florida, Alabama and Tennessee. Dr. Thomas P. Goodwyn, Chairman of the Medical Advisory Committee, has already secured the support of the corresponding officer in the adjoining States.

To establish such a Center would cost perhaps \$1,500,000. The Southeast of today, especially with some help from the Federal Government, can afford this. A bill to establish several such Regional Centers passed the Senate of the 81st Congress unanimously, and was re-introduced in the 82nd Congress, but failed to come to a vote. A similar bill (H. R. 7,341) has been thrown into the hopper for the present Congress with the support of the President. Apparently no one is willing to vote against the bill, and, if this Congress ever buckles down to work, they may pass the new bill as a part of Mr. Eisenhower's program (as it formerly was of Mr. Truman's).

Once started however, the expenses of the Center would not be very great to the Georgia tax-payer, for tax-payers in other states would pay the expenses of many of their citizens; insurance companies, labor organizations, churches and other philanthropic groups would provide much of the remainder.

Georgia has seen the value of a Regional Center for the rehabilitation of victims of poliomyelitis at Warm Springs. The Infantile Paralysis Foundation's magnificent rehabilitation plant there employs about 50 physical therapists, most of whom are serving their internships, so to speak. It is quite possible that with the progress in polio research, the demands upon the Warm Springs establishment by young paralytics will lessen in time, and other persons in need of its facilities will be able to profit by them.

Meanwhile, the Eugene Talmadge Hospital going up in Augusta and a new Grady Memorial Hospital just starting in Atlanta, it is reported, will be well equipped for physical therapy. In recent months moreover, a group in Savannah has been exploring the possibilities of opening a rehabilitation center there.

As this Committee pointed out last year, there is an urgent need for a School of Physical Therapy in Georgia. Such a school must be allied with one of the medical colleges. A first class one can, it is thought, be run for less than \$30,000 a year; Georgia cannot afford a second class school.

Care of the Disabled

The public has not been made to understand that the cost of everything involved in running a hospital has increased several times in the past twenty years. No longer is a nursing supervisor content to work 72 hours a week for \$100 a month and keep, nor an orderly to work an equal length of time for even less. Hospitals, unwilling to charge the actual cost of a bed per day, try to make both ends meet by charging extra for everything possible. They do not therefore welcome a long-term patient who requires few x-rays or laboratory determinations.

At the present time the State of Georgia has con-

siderably fewer general hospital beds than it is estimated are needed. From a utilitarian standpoint it follows that a community hospital cannot justify tying up a bed 52 weeks for a patient who has scant chance of again becoming self-supporting, when that bed might be used for 50 other patients, most of whom can be restored to health and returned to the support of their families.

However, the chronically ill patient is often best hospitalized a few days for a complete diagnosis and for such treatment as may prove necessary to get him into the best possible physical condition. But he cannot afford an indefinite stay in a general hospital, nor does he need it. At the same time, such a patient does need continuing medical supervision, and he may need visits from a registered nurse, a physical therapist, a laboratory technician or a practical nurse. From time to time he is apt to require brief hospitalization for additional diagnostic studies or for the treatment of fresh emergencies of his original troubles. He therefore needs access to a hospital.

Summary

1. While Georgia's accomplishments in the field of vocational rehabilitation are such that we may all be proud of them, they would be even greater if we had an adequate number of physical therapists. The best way to obtain these is to establish a school of physical therapy and train young men and women of the Southeast in this rather new profession.

2. The logical place for the proposed Regional Rehabilitation Center to serve the Southeast is in Georgia.

3. Physicians should more actively interest themselves in the management of chronically ill patients, whether in their own homes (where many of them will be most comfortable and happy) or in nursing homes, whether in hospitals or in hospital annexes. They should do everything in their power to make available the services of auxiliary personnel as needed. Doctors should also collaborate in providing instruction in the care of the patient to his family and other available persons.

Reference Committee recommendation—The Committee approved the report of the Committee on Chronic Illness and wishes to commend the Committee members for their fine work and also recommend that they consider the advisement of using the Alto Hospital for the establishment of a training school for physical therapists in Georgia.

House of Delegates action—recommended the adoption of the report of the Committee on Chronic Illness and the motion carried.

Report of Committee on Mental Health

J. R. Shannon Mays, Chairman

No Report.

Reference Committee recommendation—The Committee recommends that the Committee on Mental Health function next year as no report was received to date.

House of Delegates action—recommended that the Committee on Mental Health function next year and the motion carried.

Report of State Board of Medical Examiners

Grady Coker, Chairman

In June of 1953, the Board licensed 115 by examination and 68 by reciprocity. In October 1953, ten

were licensed by examination and 45 by reciprocity, which makes 238 physicians licensed to practice in the state of Georgia last year. By death and retirement there was a loss of about 60 physicians. At the present increase, in another five years the state of Georgia should have about 1,000 extra physicians in the state medical association. We have plenty of physicians in the state of Georgia at the present time. What we need more than anything else is distribution which is the sole answer to our shortage of doctors.

The Board last year discontinued reciprocity with the National Board of Examiners and about 15 or 20 other states also discontinued reciprocity. The main objection being their present method of conducting their examinations.

The Board last year licensed one man from Kentucky by reciprocity who had finished a C class school, but had had the Army service and came out of the Army with the distinguished service medal. The Board of the particular place felt that we should honor the state of Kentucky and that we should give this physician reciprocity in the state of Georgia. We also licensed a second man who finished a B class school by examination. This particular physician had had several years in an accredited hospital and was indorsed by every member of that hospital staff. The Board felt that with the added experience, he was justified in taking the examination.

In the future the Board will not admit any more Class B graduates by reciprocity or examination regardless of experience because the Board itself has adopted a rule to this effect.

You probably know during the past several years the State Board of Medical Examiners has been licensing, from year to year, displaced foreign physicians to work in state institutions. These physicians after getting their American citizenship, for several years experience were supposed to take the Board examination for license, but all of them so far have refused to take this examination. During the last session of the State Legislature we amended the medical practice act to allow the renewal of their temporary license from year to year as long as they stay in the state institutions. These particular physicians are not allowed to do any outside practice.

Reference Committee recommendation—The Committee approved the report of the State Board of Medical Examiners and wished to commend this Committee for their excellent work.

House of Delegates action—recommended that the Report of the State Board of Medical Examiners be adopted and the motion was carried.

Report of Executive Secretary

Mr. Milton D. Krueger

On assuming the position of Executive Secretary of the Medical Association of Georgia on November 1, 1953, it was evident that the program and policy of the Headquarters Office needed little change at that time. Projects and planning were well underway and the immediate task was to further the "in-progress" office work.

During this period the Executive Secretary visited neighboring state medical associations in an effort

to gain more insight into headquarters office organization and function. Further training was also gained from AMA Staff at the request of the Headquarters Office.

After a careful review and analysis of Headquarters Office function, a general plan of activity was set up to better serve the desires and needs of the component county societies. Considering the county medical society as the basic unit of the MAG, the administrative approach of Headquarters Office was "tailor-made" to suit this unit.

Headquarters Office Reorganization

(1) General Program: While the MAG policies will remain essentially the same as in past years, new administrative aspects are envisioned. The Council of the MAG committed the Association to five-point program for 1954. As approved by Council it reads:

1. Adequate Physician Care for the Citizens of Georgia
2. Voluntary Insurance Plan to be Supported by MAG Physicians
3. Increased MAG Physician Support of the American Medical Education Foundation
4. MAG Assistance to Communities in Securing Physicians Where Need Exists
5. MAG Physician Support of Better Health Programs for All, and Especially for Children and Elderly People

Other points of the program include Emergency Call Systems, M.D. Speakers for Lay Groups, Minimum Standard of Blood Banks, Disaster Defense, M.D. Secretary Course, etc.

(2) Administrative Program: To better serve the MAG membership in administering MAG programs and policy a much closer liaison with the county medical society is necessary. It appears that for practical purposes it is useless to write letters concerning Association business and expect action on the "grass roots" level. Other state medical associations employ a field secretary to visit all county medical societies at least twice annually to stimulate activity in behalf of their association. While perhaps a field secretary, per se, is not necessary, certain travel by Headquarters Office personnel is envisioned. This would facilitate Headquarters Office carrying the Association program to the "grass roots" level and also aid and serve the county medical society in solving their local problems by having Headquarters Office personnel "on the spot" to answer all queries.

Recommendation: That the Association authorize Headquarters Office personnel to visit two to three county medical societies weekly on a basis of 10 months annually. That the Association also approve travel expenses incurred in this capacity.

(3) Personnel: At present the Headquarters Office consists of the following persons in said capacities: Mr. Milton D. Krueger, Executive Secretary; Mr. John F. Kiser, Assistant Executive Secretary and *JMAG* Managing Editor; Miss Thelma Franklin, Business Manager; Mrs. Myrtice Mulligan, Secretary and Receptionist; Miss Frances Porcher, *JMAG* Editorial Assistant and Annual Session Secretary.

At the present time this staff is adequate and by a reallocation of specific duties, they will be able to effectively handle the envisioned reorganization of Headquarters Office.

Membership

Data listed below on Association membership for the year 1953 will serve to document the increased interest and activity of the MAG.

Districts	Members Dec. 31, 1953		Members Dec. 31, 1952	
	MAG	AMA	MAG	AMA
First	196	165	189	162
Second	167	107	158	99
Third	177	145	169	142
Fourth	150	108	139	103
Fifth	870	627	841	627
Sixth	206	156	186	154
Seventh	204	148	203	144
Eighth	154	128	145	120
Ninth	122	89	115	82
Tenth	292	220	252	206
Total	2538	1895	2397	1841

DISTRICT OFFICERS

First District

Samuel F. Rosen, Savannah, *President*
William H. Fulmer, Savannah, *Secretary*

Second District

Phil E. Roberson, Albany, *President*
Frank A. Little, Thomasville, *Secretary*

Third District

John H. Robinson III, Americus, *President*
T. Schley Gatewood, Americus, *Secretary*

Fourth District

J. M. Kellum, Thomaston, *President*
George Kinnard, Newnan, *Secretary*

Fifth District

W. S. Dorrough, Atlanta, *President*
C. Purcell Roberts, *Secretary*

Sixth District

William Rawlings, Sandersville, *President*
C. H. Richardson, Jr., Macon, *Secretary*

Seventh District

H. L. Erwin, Dalton, *President*
Ralph N. Johnson, Rome, *Secretary*

Eighth District

Henry T. Adkins, Waycross, *President*
Sage Harper, Douglas, *Secretary*

Ninth District

E. L. Ward, Gainesville, *President*
George T. Nicholson, Cornelia, *Secretary*

Tenth District

Bothwell Traylor, Athens, *President*
Donald W. Schmidt, Lincolnton, *Secretary*

Reference Committee recommendation—The Committee approved the report of the Executive Secretary and wished to highly commend the headquarters office staff and urge them to continue their enthusiastic efforts.

House of Delegates action—recommended the report of the Executive Secretary be adopted and the motion carried.

Resolution on Hospital Accreditation

Fred H. Simonton

WHEREAS, the American Medical Association, beginning in 1847, has been the most widely accepted organization of American Medicine, successfully operating under a time-honored Code of Ethics and a Constitution and By-Laws giving equitable representation, individually and collectively, in all of its branches; and

WHEREAS, the American Medical Association, through its Council on Medical Education and Hospitals, has conducted a most noteworthy and commendable program of accreditation, giving American Medicine the greatest number of trained and competent physicians than heretofore at any time or place in world history; and

WHEREAS, a Joint Commission on Accreditation of Hospitals was subsequently established, consisting of 20 representatives from the following organizations; American Medical Association, six votes; Canadian Medical Association, one vote; American College of Surgeons and American College of Physicians, each three votes; and the American Hospital Association, seven votes, one being exercised by a member of the Canadian Hospital Association, and

WHEREAS, one of the purposes of the Commission, as stated in the by-laws is to "conduct an inspection and accreditation program which will encourage physicians and hospitals . . . voluntarily . . . to promote high quality medical and hospital care in all its aspects in order to give patients the greatest benefits that medical science has to offer . . ." and therefore,

BE IT RESOLVED: that the House of Delegates of the Medical Association of Georgia recommend that the American Medical Association be the governing body of all medicine.

Reference Committee recommendation—The Committee approved this resolution and it was so voted.

House of Delegates action—recommended the adoption of the Resolution on Hospital Accreditation and the motion carried.

Resolution on Fluoridation of Water

John W. Turner

The delegation of the Fulton County Medical Society has been asked by the President of the Georgia Dental Association to request that the Medical Association of Georgia go on record as being in favor of the fluoridation of drinking water, I am presenting to the clerk of the House of Delegates data in regard to the fluoridation of water and request that it recommend that the Medical Association of Georgia go on record in a resolution in favor of fluoridation.

As the data given to the clerk shows, the Georgia Dental Association, the Fulton County Medical Society and the American Medical Association have already adopted resolutions to that effect.

Reference Committee recommendation—The Committee approved the resolution on Fluoridation of Water and so voted.

House of Delegates action—recommended the adoption of the resolution on Fluoridation of Water and the motion carried.

Resolution on Small Hospitals
(Under 100 Beds)

Grady Coker

WHEREAS, the present accreditation program of the Joint Committee on Hospital is not practicable and not workable when applied to the hospital of less than 100 beds,

BE IT RESOLVED, that a new system of classification be set up which will take into consideration the small hospital, the large hospital and also take

into consideration a teaching and a non-teaching hospital.

BE IT FURTHER RESOLVED, that the American Medical Association with its efforts on standardization and accreditation program assume all the responsibilities and maintain its voting strength by absorbing the six votes now exercised by the College of Surgeons and the College of Physicians.

Reference Committee recommendation—The Committee recommended that this resolution be reworded keeping the original intent of the resolution and recommended its adoption.

House of Delegates action—recommended the adoption of the resolution on Small Hospitals (Under 100 Beds) as recommended by the Reference Committee and the motion carried.

Chairman Dougherty moved for the adoption as a whole of the Report of Reference Committee No. 3 and the motion carried.

REPORT OF REFERENCE COMMITTEE
NO. 4

David Thomas, Chairman

The following reports as presented to this Committee are printed in full with the Reference Committee's recommendation and the action pursuant to it by the House of Delegates.

Seventh District Councilor's Report

D. L. Wood

The Seventh District is still making medical progress. The District meetings are well attended, with excellent scientific papers. As of December 31, 1953 there were 204 members of the Medical Association of Georgia and 148 members of the A.M.A. in the District, this being an increase of one to four over 1952.

Seventh District Membership

Counties	Members Dec. 31, 1953		Members Dec. 31, 1952	
	MAG	AMA	MAG	AMA
Barrow	9	9	10	8
Carroll-Douglas-Haralson	38	18	35	16
Chattooga	7	7	6	6
Cobb	37	32	32	28
Floyd	46	35	54	37
Gordon	10	8	9	7
Polk	17	11	17	11
Walker-Catoosa-Dade	20	16	20	19
Whitfield	20	12	20	12
Total	204	148	203	144

Reference Committee recommendation—The Committee approved the Seventh District Councilor's report and commended the Councilor on the work that has been done in that district, and it was so voted.

House of Delegates action—recommended the adoption of the Seventh District Councilor's report and the motion carried.

Eighth District Councilor's Report

Neal F. Yeomans

Eighth District Membership

Counties	Members Dec. 31, 1953		Members Dec. 31, 1952	
	MAG	AMA	MAG	AMA
Appling	8	7	7	6
Coffee	14	8	13	5
Glynn	23	21	21	18

South Georgia (Berrien- Clinch-Cook-Echols- Lanier-Lowndes)	35	30	38	35
Telfair	11	10	11	9
Ware	54	43	46	38
Wayne	9	9	9	9
Total	154	128	145	120

Addendum

(For Information Only)

In regard to the question of a financial audit's being published in the *Journal*, Council voted May 2 to publish the complete audit for 1952, 1953 and 1954 as soon as available.

Reference Committee recommendation—The Committee approved the report of the Eighth District Councilor and commend the Councilor on his work and it was so voted.

House of Delegates action—recommended the adoption of the Eighth District Councilor's report and the motion carried.

Third District Vice-Councilor's Report

Guy Jackson Dillard

Our Councilor, Dr. Gus Elliot, is so efficient and experienced that I have had very little to do in the District as a whole. Most of my work has been locally. I have made an effort to keep our Medical Society informed as to the general activities of the Association. It is my feeling that the local Medical Society is functioning better than ever. The reports that we receive concerning the forums put on by the Fulton County Medical Society have been so encouraging that we have already begun a similar forum here in Columbus. March 11 is the date of our third forum, and we are highly pleased with the results.

We have begun publishing a bulletin which so far has met with success. Our last undertaking which is now in process—namely, the establishment of a special committee to deal with lay grievances, ethics and etcetera.

We have spent considerable money in bringing in good speakers and have invited physicians from the outlying counties. The attendance from these counties has been very good.

The above activities, in my way of thinking, would doubtless spread to towns smaller than Columbus just as your forums in Fulton County have stimulated Muscogee County in similar activities.

Reference Committee recommendation—The Committee approved the report of the Third District Vice Councilor and commended him on the fine work that is being accomplished.

House of Delegates action—recommended the report of the Third District Vice Councilor be adopted and the motion carried.

Medical Defense Committee Report

Marion C. Pruitt, Chairman

All malpractice suits against members of The Medical Association of Georgia should be brought to the attention of your Medical Defense Committee, whether or not the member is protected with malpractice insurance.

Uninsured members, when sued, are defended by the Association's attorney, with assistance of a local attorney where needed.

Insured members are defended by an attorney employed by the insurance company. However, if

the suit is for an amount greater than the insurance coverage, the member is entitled to the services of the attorney for the association, and, when requested, the Medical Defense Committee will ask him to become associated in the case with the attorney employed by the insurance company.

Also, the Medical Defense Committee ought to be kept advised of all suits against all doctors at all times. We must know what is the basis of these suits so that we can get out the word and our doctors can avoid them by being on guard.

Addendum

(Letter received from Marion Pruitt, Chairman)

Dr. H. L. Cheves

Union Point, Georgia

Dear Dr. Cheves:

I regret that I cannot make the Macon meeting because of my health.

I am asking that you make this report to the House of Delegates.

Enclosed is report of the legal Defense Committee submitted by Mr. John Dunaway, attorney for the Association. You will see that we have had 27 suits during the year. Eleven have been closed, 16 are still pending.

Thanking you, I am

Sincerely

MARION C. PRUITT, Chairman

Medical Defense

Medical Association of Georgia

CC: Dr. Henry Poer

Dr. William P. Harbin, Jr.

(Also introduced were the official Association records and the specific records of each suit that came up during the year.)

Reference Committee recommendation—The report from the Committee on Medical Defense was received and reviewed and they are to be commended for the work that they have done during the past year, and we feel sure that they will continue that function during the ensuing year. Twenty-seven malpractice suits were reported during the past year, which is a considerable increase over those occurring in previous years. The Committee takes the liberty of recommending to the members of the Medical Association of Georgia that they check their malpractice insurance and be certain that they are adequately covered by this insurance. The Committee further recommends that each member of the Medical Association of Georgia check his insurance coverage as any bodily injury incurred in the doctor's office is not covered by malpractice insurance and we feel that this should be called to their attention.

The Reference Committee feels that, after due consideration, it is our duty to call to the attention of the members of the Medical Association of Georgia their responsibility in not settling unjust claims simply in order to expedite the closing of a case; we feel that this would simply encourage unscrupulous parties to enter suit more frequently and to cause added expense and embarrassment.

House of Delegates action—recommended the adoption of the report of the Committee on Medical Defense and approved the suggestions by the Reference Committee and the motion carried. David Henry Poer expressed regret that the Chairman of this Committee was ill and unable to attend, and the House of Delegates expressed this in the form of a motion which also carried.

Cancer Committee Report

J. Elliott Scarborough, Chairman

The Committee on Cancer continues to serve the Georgia State Cancer Control Service in an advisory capacity. The relationship is a healthy one and matters affecting the public and profession have come up

during the year and have been dealt with in what we consider to be a satisfactory manner. We, of the Committee, also enjoyed the support of the Georgia Division of the American Cancer Society under the direction of Mr. Lon Sullivan. The close collaboration of these separate agencies contribute to the success of the Cancer Program in Georgia and serves as a model for the cooperation that is necessary in this field.

At the request of Dr. W. J. Murphy, a meeting of the Executive Committee was called to discuss the program for the State Health Department, which was threatened with having to reduce services for indigent patients. It was decided that a letter should be written to all doctors outlining the purpose of the Cancer Control Program and suggestions were made whereby savings could be made in the method of referring patients and attempting to limit the amount of hospital care. A review of the criteria for eligibility for the program also was discussed. The Committee suggested that this information be disseminated and accordingly each doctor in the State was circularized with a review of the policy and procedure of the program under date of August 1, 1953. This, and other aims at economy, have resulted in a continuing of the program without lessening the benefits and care to the needy.

The Committee approved the sending of the Cancer Bulletin to members of the profession by the Georgia Cancer Control Service.

The Cancer Committee approved a motion that all the Directors of the State Aided Cancer Clinics be brought to Atlanta for a review of the program and discussion in improving it. This has never been called formally by the Chairman because of a lack of appropriate time after polling the membership. This has been accomplished, however, from a practical viewpoint since the majority of the doctors attended the annual meeting of the American Cancer Society on January 15, 1954, at which Dr. W. J. Murphy outlined the aims of the Cancer Control Program in the State.

The Committee has sponsored educational and scientific programs for the Muscogee Medical Society at Columbus, Georgia, The Medical College of Georgia at Augusta, as well as the program for the American Cancer Society here in Atlanta.

The Chairman wishes to thank all the members of the Committee, and especially the members of the Executive Committee, for their complete cooperation and perfect attendance at all called meetings.

Reference Committee recommendation—The Committee commends Dr. J. E. Scarborough, Chairman, for his excellent report, and the invaluable work that has been done by that Committee. The Committee also wishes to pay tribute to the untiring efforts of the Committee on Cancer and approves their report; it was so voted.

House of Delegates action—recommended the adoption of the report of the Committee on Cancer and the motion carried.

Report of Committee on Constitution and By-Laws

Allen H. Bunce, Chairman

The first meeting of the Committee was held at the Academy of Medicine, Atlanta, on November

5th, 1953. Those present were Doctors William P. Harbin, President; David Henry Poer, Secretary-Treasurer; H. Dawson Allen, J. W. Chambers, Allen H. Bunce and Mr. Milton D. Krueger, and Mr. John F. Kiser.

The second meeting of the Committee was held at the Capital City Club, Atlanta, on February 23, 1954. Those present were Doctors William Harbin, President; Peter Wright, President-Elect; David Henry Poer, Secretary-Treasurer; Enoch Callaway, J. W. Chambers, Allen H. Bunce and Mr. Milton D. Krueger.

The following is the report of the Committee:

AMENDMENTS TO CONSTITUTION

ARTICLE VI

COUNCIL

Sec. 2. The Council shall consist of the President, President-Elect, the immediate Past-President, the Secretary-Treasurer, and one Councilor from each Congressional District in the State of Georgia.

Reference Committee recommendation—The Committee approves the change in Article VI, Section 2.

ARTICLE IX

OFFICERS

Sec. 1. Officers. The officers of the Association shall be a President, President-Elect, two Vice-Presidents, Secretary-Treasurer, Speaker of the House of Delegates, Vice Speaker of the House of Delegates, and one Councilor and a Vice Councilor from each of the Councilor Districts.

Sec. 3. Terms of Officers . . . Other Officers shall be elected for terms of one year each, except the Secretary-Treasurer, the Councilors and Vice Councilors, who shall serve for three years. One-third, or as near as may be, of the Councilors and Vice-Councilors shall be elected annually.

Reference Committee recommendation—The Committee approves the change in Article IX, Section 1 and Section 3.

ARTICLE X

FUNDS AND EXPENSES

(Amend second paragraph as follows):

The Council shall submit an annual budget for the next succeeding fiscal year to the House of Delegates. This budget shall not exceed the anticipated current income for the period covered by it. The Council shall manage the finances of the Association and shall supervise all funds, investments and expenditures of the Association. All resolutions providing for appropriations, recommended by the Council, shall be included in the annual budget, subject to final approval of the House of Delegates.

Reference Committee recommendation—The Committee approves the change as presented in Article X.

ARTICLE XI

OFFICIAL PUBLICATION

The official publication of the Association shall be The Journal of the Medical Association of Georgia, in which shall be published all official Association notices, abstracts of transactions of the House of Delegates and general meetings of the Association, the annual budget, complete financial report and abstracts of meetings of Council.

Reference Committee recommendation—The Committee recommends that Article XI be changed to read as follows: "The official publication of the Association shall be the *Journal of the Medical Association of Georgia*, in which shall be published all official Association notices, abstracts of transactions of the House of Delegates and general meetings of the Association, the annual budget, complete financial report as directed by Council, and abstracts of meetings of Council."

(NOTE: These amendments to the Constitution may not be voted on until the 1955 Annual Session.)

AMENDMENTS TO THE BY-LAWS

CHAPTER I

MEMBERSHIPS

Sec. 5. Associate Members . . . Associate Members shall be entitled to all the rights and privileges of the Association except that they shall not pay dues or receive *The Journal* without subscription thereto.

Reference Committee recommendation—The Committee approves the changes in Chapter I, Section 5.

Sec. 8. Scientific Members. There shall be created a new division of membership to be known as Scientific Membership. The privileges of membership under this classification shall entitle the holder thereof to all phases of the Association's activities pertaining to the study of scientific medicine, and shall include the right to attend all scientific meetings, postgraduate study courses, and scientific sessions of component organizations.

Scientific members shall pay no dues and shall not be entitled to vote or hold office. They shall not be entitled to Medical Defense or receive *The Journal* except by regular subscription.

Reference Committee recommendation—The Committee approves the change in Chapter I, Section 8.

CHAPTER III

HOUSE OF DELEGATES

Sec. 4. The House of Delegates shall be presided over by the Speaker or, in his absence, by the Vice Speaker. In the absence of both, a delegate agreeable to it may preside.

Reference Committee recommendation—The Committee approves the change in Chapter III, Section 4.

CHAPTER IV

COUNCIL

Sec. 3. The Council shall set up an Executive Committee composed of the President, Secretary-Treasurer, Chairman of the Council and two other members of the Council. The President shall be the chairman of the Executive Committee. It shall meet not less often than bi-monthly to review the affairs of the Association . . .

Sec. 7. . . . The Vice-Councilor shall assist the Councilor in the performance of his duties. He becomes a voting member of the Council only in the absence of the Councilor from his district.

Sec. 11. . . . The Council shall propose an annual budget for the fiscal year beginning January 1st after each annual session. This proposed budget shall be prepared by the Committee on Auditing and Appropriations for the consideration of the Council at the last meeting in the last quarter of each year. This budget shall be presented to the House of

Delegates for its approval after which it becomes effective . . .

Sec. 12. . . . (Omit the following words at the end of this paragraph): . . . "except properly to account in writing for its distribution to the House of Delegates."

Reference Committee recommendation—The Committee approves the changes in Chapter IV, Section 3, Section 7, Section 11 and Section 12.

CHAPTER VI

DUTIES OF OFFICERS

Sec. 4(c) . . . (Add the following sentence at the end of this paragraph): This financial report shall be published in *The Journal* as soon as practicable after the end of each fiscal year.

Reference Committee recommendation—The Committee approves the change in Chapter VI, Section 4(c).

CHAPTER IX

STANDING COMMITTEES

Sec. 1. The Standing Committees of the Association shall be as follows:

- (A) Committee on Scientific Work
- (B) Committee on Legislation
- (C) Committee on Medical Education
- (D) Committee on Medical Defense
- (E) Committee on Professional Conduct
- (F) Committee on History and Vital Statistics
- (G) Committee on Public Health
- (H) Committee on Maternal and Infant Welfare
- (I) Committee on Rural Health
- (J) Committee on Industrial Health
- (K) Committee on Public Relations
- (L) Committee on Cancer
- (M) Committee on Insurance
- (N) Committee on Veterans Affairs
- (O) Committee on Constitution and By-Laws
- (P) Committee on Awards
- (Q) Committee on Woman's Auxiliary
- (R) Committee on Hospitals

NOTE: The above capital letters of the alphabet shall be used throughout CHAPTER IX to designate these committees instead of the present wording—"Sec." . . .

Sec. 3.—A. Omit "the committee has the authority to make awards for the best scientific exhibits presented each year."

Sec. 4.—B. (Add)—The President may appoint for one year an Advisory Committee of any number he deems advisable.

Sec. 5.—C. The Committee on Medical Education shall consider and devise means of extending the educational work of the Association for the benefit of its members, working with the component societies wherever possible and serve for the Council on Medical Education of the American Medical Association in this state. All problems relating to the post graduate study of medicine shall be referred to this Committee.

Sec. 9.—G. Omit the last paragraph in reference to Civil Defense. (Add)—The President may appoint for one year an Advisory Committee of any number he deems advisable.

Sec. 10.—H. (Omit the last sentence in this paragraph.)

Sec. 12.—J. (Omit the first two sentences and substitute the following for them): The Committee on Industrial Health shall be composed of five members.

Sec. 16.—N. The Committee on Veterans Affairs shall represent the Association in all matters pertaining to all veterans.

Sec. 17.—O. The Committee on Constitution and By-Laws shall recommend to the House of Delegates any amendments which seem to be necessary or advisable. Proposed amendments shall be referred to this Committee before action is taken by the House of Delegates.

Sec. 18.—P. The Committee on Awards shall have complete charge of all awards made by the Association or in the name of the Association. The decisions of this Committee shall be final in reference to recipients.

Sec. 19.—Q. The Committee on the Woman's Auxiliary shall cooperate with, advise and direct the Auxiliary in all matters concerning the Association.

Sec. 20.—R. The Committee on Hospitals shall pursue a continuing study of the relation of the medical profession to the operation of public and voluntary hospitals within this State, and shall, when indicated, confer with the State Department of Health, the Georgia State Hospital Association and all related organizations and make recommendations to the Association.

Reference Committee recommendation—The Committee recommends that Chapter IX, Section 3, Section 4, Section 5, Section 9, Section 10, Section 12, Section 16, Section 17, Section 18, Section 19 and Section 20 be approved as presented.

CHAPTER X

SPECIAL COMMITTEES

Omit: "The following is now authorized: 1. Woman's Auxiliary."

The Committee respectfully asks the House of Delegates through its appropriate Reference Committee to study and recommend any change it sees fit in the following:

BY-LAWS

CHAPTER I

Sec. 7. Life Members. A Life Membership may be granted by the House of Delegates, upon recommendation of the component county society, to any physician who has had not less than forty years of active membership in the Association or has passed his seventieth birthday. He shall not be subject to payment of dues.

(NOTE: *Changes in the By-Laws are effective immediately upon approval of the House of Delegates.*)

STANDING RULES

1. The Committee on Scientific Work shall prepare the program for all scientific meetings of the Association at all Annual Sessions. It may divide the scientific work into whatever number of sections that seem advisable for the particular Annual Session. It shall appoint temporary officers for all sections until such time as the sections apparently become permanent. As each section becomes established it shall elect its own officers subject to such rules and regulations as may be laid down by the Committee on Scientific Work. The program for all General

Meetings shall be prepared by the Committee itself. In its work the Committee shall be subject to the approval of the Council and, when necessary, to the House of Delegates.

2. The Executive Committee of the Council shall constitute the Publication Committee of *The Journal*.

Reference Committee recommendation—The Committee approves the changes in Standing Rules as presented; the Committee approves the change of the Special Committees, Chapter X as presented and the Committee approves the change in By-Laws, Chapter I, Section 7.

House of Delegates Action—recommended the adoption of the report of the Committee on Constitution and By-Laws as presented by Reference Committee No. 4, and the motion carried.

Report of A. W. Calhoun Lectureship Committee

Glenville Giddings, Chairman

The Committee on the Calhoun Lecture met last fall and, after consideration, it was decided to extend an invitation to the Honorable Richard Nixon, Vice-President of the United States, to address the Medical Association of Georgia on his impressions of the Far East, as a result of his recent travels in that area.

Upon receipt of the invitation, Mr. Nixon advised the Committee that, due to circumstances beyond his control, he would be unable to leave Washington on the date specified.

Due to the lateness of the date, the Committee decided to omit the Calhoun Lecture for the 1954 meeting. A suitable speaker will be selected for the 1955 meeting. This decision met with the approval of Dr. F. Phinizy Calhoun.

Addendum

We had planned to have Vice-President Nixon address the Association at the meeting in Macon. However, I have been advised by Mr. Nixon that he will be unable to leave Washington at that time. This information has been transmitted to Dr. Phinizy Calhoun, and it was his thought, in which I agreed, that we would not have the Calhoun lecture at the present meeting, but delay it until 1955. This will allow the honorarium to increase for next year.

Reference Committee recommendation—The Committee accepts this report and the addendum thereto, and extends to the Calhoun Lectureship Committee our appreciation for attempting to provide an address by the Vice-President of the United States, Mr. Nixon.

House of Delegates action—recommended that the report and addendum of the Abner Wellborn Calhoun Lectureship Committee be adopted and the motion carried.

Report of Liaison Advisory Committee to the Georgia Society for Crippled Children

H. Walker Jernigan

There has been only one matter brought to the attention of the Chairman of this committee during 1953-54.

About June 22, 1953, Miss Mary Webb, Executive Secretary of the Georgia Society for Crippled Children, Inc., asked me to attend a meeting of her organization as a representative of the Medical Association of Georgia. At this first meeting, it developed that the Georgia Society for Crippled Children, Inc.,

proposed to conduct a survey of the State of Georgia to determine the number of physically handicapped children in the state, as well as the services available in the state for the care of these children. The funds for this survey were to be furnished by the Cerebral Palsy Society and amounted to about \$9,000.00. To outline and conduct this survey, the Society employed Dr. Samuel Wishik, a pediatrician from Pittsburgh, Penn.

Subsequent to this meeting, several more meetings were held to discuss the procedure to be followed in conducting this study. A good many interested organizations were represented at these meetings; the Medical Association of Georgia, the Woman's Auxiliary to the Medical Association of Georgia, the State Board of Health, State Crippled Children's Service, Cerebral Palsy Society, State Vocational Rehabilitation Department, and the American Academy of Pediatrics.

The first step was a survey of state institutions made by Dr. Wishik. Second, due to the cost of conducting such a survey, it was decided to make a very detailed study of one single area. Clarke and adjoining Oconee County were selected. The population of these two counties would comprise a cross section of a rural and urban population which would not be too large and make such a study unwieldy.

Your chairman reported on this plan to Dr. William Harbin, President of the Medical Association of Georgia, and representatives of the Clarke County Medical Society were notified. The matter was then referred to the Council for action. One meeting with a sub-committee of the Council was held, and the matter gone into from all angles. The Council approved this plan with the condition that it be approved by the Clarke County Medical Society. The Clarke County Medical Society approved the plan and the survey is now in progress.

Reference Committee recommendation—This report is received for information only, and we wish to commend them for the work they have been doing.

House of Delegates action—recommended that the report of the Liaison Advisory Board to the Georgia Society for Crippled Children be accepted and the motion carried.

Report of Advisory Committee to the Clarke-Oconee County Study

Mark S. Dougherty, Jr., Chairman

This committee was appointed to represent the Association in advising and consulting with individuals, including Dr. Samuel M. Wishik, University of Pittsburgh, who are in any way involved in conducting the Quantification Phase of the Georgia Study of Services for Handicapped Children in Clarke and Oconee Counties.

The Chairman has kept in communication with the Executive Director of the Georgia Society for Crippled Children, receiving progress reports, advising and counseling with regard to all developments of the Clarke-Oconee Study. He participated in a discussion of this project at the Annual Meeting of the Georgia Society for Crippled Children. The approved sub-committee appointed to advise in selecting and arranging for the needed professional per-

sonnel to participate in the Assessment Clinic Sessions in Athens was composed of Dr. Hugh Wood, Dean, Emory University School of Medicine; Dr. Edgar Pund, President, Medical College of Georgia; Dr. Fred Hodgson, Medical Director Crippled Children's Division, State Department of Public Health; and Dr. Robert L. Bennett, Medical Director Warm Springs Foundation.

This Committee asked the assistance of physicians in special fields and succeeded in arranging for the needed personnel on a voluntary basis. One hundred eighty-five days of professional service were devoted to examining over seven hundred children, which included mental retardation, epilepsy, cardiac, cosmetic defect, cleft palate, orthopedic, cerebral palsy, orthodontic, vision, speech, hearing and personality defects clinics March 1 through April 2. Professional personnel included forty-five individual physicians and dentists, in addition to medical social workers, psychologists, public health nurses, speech correctionists, physical therapists and audiometric and vision testing technicians. When the Study is completed, reports will be submitted to this Committee for review.

Dr. H. Walker Jernigan and Doctor Mark S. Dougherty spent Thursday morning, March 18th, in Athens, observing the work of the survey group in Clarke County and reviewing the methods and records that are being followed in arriving at diagnosis and compiling the statistical information to be included in the survey.

Doctor John McPherson has been consulted personally and states that the doctors in Athens have not objected to this survey and that it is running smoothly and that no particular problems have arisen in the conducting of the survey thus far. The survey has been supported by the local service groups and by the community at large in Clarke and Oconee Counties.

Addendum

The examination of children with handicaps in the Clarke-Oconee County Survey has been completed. Over 600 children were examined.

At present reports are being prepared to be mailed to doctors who had private patients in the survey.

The study went smoothly with Society cooperation of all groups involved. The statistical material will be received and a final report rendered later.

Reference Committee recommendation—The Committee commends the Advisory Committee to the Clarke-Oconee County Study for the excellent work they have done and approve their report for information.

House of Delegates action—recommended that the report of the Clarke-Oconee County Study be accepted and the motion carried.

Report of State Medical Education Board

C. L. Howard

Constitutional Amendment

The 1951 General Assembly of the State of Georgia enacted a law providing for an amendment to the Constitution of the State of Georgia for the creation of the State Medical Education Board. The

people of the State of Georgia ratified this Constitutional amendment in November of 1952.

The Constitutional amendment provides that the State Medical Education Board consist of five members as follows: President of the Medical Association of Georgia, immediate past President of the Medical Association of Georgia, and three qualified electors of the State of Georgia appointed by the Governor. The three members appointed by the Governor hold office for a term of four years. Vacancies on the Board will be filled by appointment of the Governor for the unexpired term.

The secretary of the Board is the person who is serving as the secretary of the Board of Regents of the University System of Georgia.

Under the Constitutional amendment the Board is charged with receiving and acting upon all applications for loans or scholarships made by students who are *bona fide* citizens and residents of the State of Georgia, who desire to become doctors of medicine, and who have been accepted for enrollment in an accredited medical college within the United States. The purpose of the loans and scholarships is to enable recipients to obtain a standard medical education which will qualify them to become licensed, practicing physicians within the State of Georgia. It is the duty of the Board to make a careful and full investigation of the ability, character and qualifications of each applicant and determine his fitness to become the recipient of a loan or scholarship. The investigation of the applicant includes a report on the ability of the applicant, or of the parents of the applicant, to pay his own tuition at a medical college. The Constitutional amendment provides that the Board in granting the loans and scholarships shall give preference to qualified applicants who, or whose parents, are unable to pay the applicant's tuition at a medical college.

The loans or scholarships do not exceed \$5,000.00 to any one person and are paid in annual installments not exceeding \$1,250.00 per annum. The loans or scholarships may be repaid as follows:

- a. The full amount of the loan shall be repaid to the State of Georgia in cash in full with 4 per cent interest. Payments are to be made annually. The first annual payment to be due on or before one year from the date the student completes his internship.
- b. The student may repay the loan in services by practicing his profession at some place within the State of Georgia to be approved by the State Medical Education Board. One-fifth of the loan, together with interest thereon, to be credited to the student for each year of practicing his profession in the designated community. No annual interest on the loan shall be paid during such practice or service. After the fifth full year of practice the student shall be relieved from further obligations under his contract.

Each applicant before being granted a loan or scholarship must enter into a contract with the State of Georgia agreeing to the terms and conditions

upon which the scholarship and loan is granted to him.

The purpose and intent of the Constitutional amendment is to bring about an adequate supply of doctors of medicine in the more sparsely populated areas of the State of Georgia by increasing the number of medical students from Georgia in the various medical colleges, and inducing a sufficient number of the graduates from medical colleges to return to Georgia and practice their profession.

Board Members

On April 1, 1953, the date that the Board came into existence, Dr. C. F. Holton of Savannah was serving as President of the Medical Association of Georgia and Dr. W. F. Reavis of Waycross was the immediate past President of the Association. Governor Herman E. Talmadge appointed Dr. C. L. Howard of Pelham, Dr. John W. Mauldin of Alma, and Dr. J. Hubert Milford of Hartwell to membership on the Board. These five gentlemen composed the membership of the Board until May of 1953. In May of 1953 the Medical Association of Georgia elected Dr. William Harbin of Rome as its President and, as provided by the Constitutional amendment, Dr. Harbin became a member of the Board and Dr. Reavis went off the Board.

At the meeting of the Board on April 1, 1953, Dr. C. L. Howard was elected Chairman of the Board and Dr. John W. Mauldin was elected Vice-Chairman.

Appropriation

The 1953 General Assembly of the State of Georgia appropriate \$25,000.00 to the State Medical Education Board for the fiscal year beginning July 1, 1953, and ending June 30, 1954, for the granting of fourteen scholarships, and appropriated \$45,000.00 for the fiscal year beginning July 1, 1954, and ending June 30, 1955, for the granting of twenty-eight scholarships.

Governor Herman E. Talmadge, upon being informed of the large number of applications for the 1953-54 academic year, allocated an additional sum of \$16,000.00 to the Board for the fiscal year beginning July 1, 1953, so that the Board might grant a total of twenty-five scholarships, and approved an additional allocation of \$32,000.00 to the Board for the fiscal year beginning July 1, 1954, so that the Board might continue the twenty-five scholarships and grant twenty-five new scholarships for the 1954-1955 academic year. These additional allocations gave the Board a total of \$41,000.00 for the 1953-54 fiscal year and \$77,000.00 for the 1954-55 fiscal year.

Scholarships

Prior to July 1, 1953, the Board received sixty-eight applications for the twenty-five scholarships available for the 1953-54 academic year from students who were enrolled in an accredited medical college or who had been accepted for admission to an accredited medical college in September of 1953. Reports from a commercial credit company were received on the applicants and their families. All applicants were interviewed by the Secretary of the Board. Each interview lasted approximately one

hour. Six references were contacted for additional information on each applicant. From the information obtainable, it was found that nearly all of the applicants were in need of financial assistance. In many cases the applicants would be unable to continue their medical education, without financial assistance.

The Board on July 1, 1953, granted twenty-five scholarships, twenty-one to white medical students and four to Negro medical students. The Board also approved five alternates. Two of the recipients, one a white and the other a Negro medical student, received funds from other sources and declined their scholarships. Therefore, scholarships were awarded to the first and second alternates, a white and a Negro medical student.

Each scholarship was in the amount of \$1,250.00 and each was granted on the basis of need in accordance with the Constitutional amendment. Because of the great need for doctors in rural areas of the State, the scholarships were granted on the condition that the recipients, upon completion of their internships, would repay the scholarships by practicing in communities of 5,000 or less population.

Applications for 1954-55

The Board is receiving applications now for scholarships for the 1954-55 academic year. From all indications the Board will receive as many applications for the 1954-55 academic year as it did for the 1953-54 academic year. Application forms may be received by writing to the Secretary, State Medical Education Board, Room 400, 20 Ivy Street, Southeast, Atlanta, Georgia. All applications for the 1954-55 academic year must be filed with the Secretary on or before June 1, 1954, for consideration by the Board when it meets on July 7, 1954.

Reference Committee recommendation—The committee wishes to thank Dr. C. L. Howard, Chairman of this Committee for the constitutional amendment to the State of Georgia and the excellent work that they have done for this Committee. Accepted for information.

House of Delegates action—recommended that the report of the State Medical Education Board be accepted and the motion carried.

Report of the President of the Woman's Auxiliary Mrs. Leo Smith, President

It has been both an honor and a privilege to serve as president of the Auxiliary to the Medical Association of Georgia this year. The opportunity to become better acquainted with the members throughout the State and to contact the officers of the Southern and National Auxiliaries has been a pleasure I shall never forget.

While working toward our goal of making every eligible doctor's wife in Georgia a member, we have tried to perfect the state organization and to strengthen each county unit. Although we have no new county auxiliaries to report, we are glad to announce the reorganization of the Auxiliary to the Tenth District Medical Society. Due mainly to the efforts of Mrs. Ralph Chaney, this auxiliary was reactivated in Athens on February 18. Our total membership

has increased to more than 1,350. We have 36 active county units and 36 members-at-large.

The work of the Auxiliary is in two fields. We assist the Medical profession in every way possible and we work toward the advancement of health education. Two of the Auxiliaries are establishing medical libraries in local hospitals. Others have assisted the county society in putting on Health Forums. Every auxiliary has reported good fellowship at the Doctor's Day parties.

The work of the Auxiliary in the field of Health Education is in community service. Realizing that the greatest potential for service lies in the contact of the individual members in various lay organizations we have stressed the importance of participation in community organizations. Every county has reported that the members have worked through the other organizations in the health committees, as well as for the philanthropic foundations that are working for the prevention and treatment of acute and chronic diseases. Special projects that auxiliaries have begun this year are a Walking Blood Bank, a loan closet of sick room supplies for the use of the Visiting Nurse Association in the care of indigent patients, staffing refreshment centers in the county hospital, spearheading the organization of a Hospital Auxiliary, spearheading the organization of Better Health Councils, health exhibits at county fairs, cooperating in the education program for home-bound children. Some members-at-large cooperated with the survey of crippled children. Another member has made records of classical books for the use of the blind.

Throughout the state, the auxiliaries have taken a greater interest in Civil Defense. Many have sponsored both Home Nursing and First Aid courses. Several of the members have been the instructors. Practically every Auxiliary has had a program on Civil Defense.

Interest is continuing in the recruitment of nurses. The auxiliaries have sponsored Future Nurses' Clubs in the various high schools and have established Nurse's Loan Funds. In an effort to show the nurses how much the doctors' wives appreciate their contribution to the health of the community, two auxiliaries have redecorated the Nurses' Homes. Others have given parties and shown other special courtesies.

Because our Student Loan Fund has not been much in demand for the past few years, that committee has studied the possibilities of changing the administration of the Loan Fund so that it will be more active.

There have been several interesting papers on the early history and practice of medicine in Georgia sent in to the Research in Romance of Medicine file. Most of the pictures of the past presidents of the Association and the Auxiliary have been procured for the Association office.

We are proud of the large increase in Today's Health subscriptions. One of our goals for the year was "a Today's Health subscription in the reception room of every doctor and dentist in the State as well as in all school and public libraries." We have not met the goal, but we have made good progress.

We have also increased our number of subscriptions to the A.M.A. Auxiliary's publication, the Bulletin.

The committee on Mental Health is new with the Auxiliary this year. Nearly all of the Auxiliaries have cooperated by studying the local and state facilities for the mentally ill. Several auxiliaries had programs on various phases of the Mental Health problem.

We have also aimed toward securing a better informed auxiliary membership. At each county meeting time was allowed on the program for information on the political and legislative issues that pertain to medicine. We have talked a great deal about the qualifications of a good doctor's wife. We have read with interest and entertainment the articles on this subject in the Medical Economies. We have tried to help medicine in general by improving our own public relations. We have promoted better fellowship among our own members. Some auxiliaries have organized bridge groups where they can meet informally and know each other better.

As the president, I attended the A.M.A. Convention in June, S. M. A. Convention in October, and the Conference of Presidents and Presidents-elect in Chicago in November. There I participated on the Organization Panel. I was honored to be invited to the A.M.A. sponsored regional Legislative Conference held in Atlanta in January. I reported on the activities of the Auxiliary to the Civil Defense School in Athens, and also attended a meeting of the Civil Defense Woman's Executive Committee. I represented the Auxiliary at a called meeting of the Better Health Council with the Rural Health Committee of the Medical Association of Georgia. I made one radio recording favoring the Fluoridation of water. At the request of the president of the Georgia Federation of Women's Clubs, I gave a brief summary of our work at their Convention. I have presided over four executive board meetings, made brief talks at eighteen county auxiliary meetings and six district meetings, and written four articles for the Auxiliary News.

In behalf of the Auxiliary, I want to express our appreciation to the Medical Association for its continued support of our activities. The president-elect, Mrs. Shelley C. Davis, and I are grateful for the trip you gave us to Chicago to attend the Conference. It was at this meeting that we received the knowledge and inspiration that made our planning more effective. Your continued support of the Auxiliary News makes this publication possible. We feel that the News helps promote unity and continuity of effort among the county units.

I want to express my personal appreciation to Dr. William Harbin, President, Medical Association of Georgia, to Dr. Ralph Chaney and the other members of the Advisory Committee, and to Mr. Milton Krueger, Executive Secretary, for their very valuable assistance. And many thanks to my husband and children who have willingly shared my time and energy with the Auxiliary. I want to thank the members of the executive board for their loyalty and cooperation. Furthermore I want to express my admiration and respect for the work done by each aux-

iliary member in the state. What we have accomplished this year has been due to the loyalty of each individual member in the wholehearted participation in all our activities both serious and social.

Officers of the Woman's Auxiliary

President—Mrs. Leo Smith	Waycross
President-elect—Mrs. Shelley C. Davis	Atlanta
First Vice-President—Mrs. Robert C. Major	Augusta
Second Vice-President—Mrs. William K. Jordan	Macon
Third Vice-President—Mrs. Virgil B. Williams	Griffin
Recording Secretary—Mrs. W. P. Stoner	Sylvester
Corresponding Secretary—Mrs. H. A. Seaman	Waycross
Treasurer—Mrs. W. Loyd Osteen	Savannah
Historian—Mrs. T. A. Sappington	Thomaston
Parliamentarian—Mrs. Lee Howard, Sr.	Savannah

Advisory Committee

Dr. Ralph Chaney, <i>Chairman</i>	Augusta
Dr. Enoch Callaway	LaGrange
Dr. A. M. Phillips	Macon
Dr. W. F. Reavis	Waycross
Dr. C. F. Holton	Savannah

Reference Committee recommendation—The Committee has reviewed Mrs. Leo Smith's excellent report, and words are inadequate for us to express our deep appreciation for the excellent work that has been done by the officers and members in our behalf.

House of Delegates action—recommended that the report of the Woman's Auxiliary be adopted and the motion carried.

Resolution on Professional Conduct and Ethics
Herbert Alden

WHEREAS, during recent years certain members of this Association have become increasingly alarmed over the trend away from strict adherence to the principles of medical ethics and conduct laid down by our distinguished forbears; and

WHEREAS, during recent years certain specific instances have come to light which in no way reflect credit upon the character of the medical profession in this State; and

WHEREAS, the delegation from the Fulton County Medical Society clearly recognizes that it does not stand blameless nor places itself in any exalted position; and

WHEREAS, the Medical Association of Georgia now and in the past has professed to foster and promote only those interests adhering to the highest standards of moral and professional conduct, and for this purpose has a duly appointed Committee on Professional Conduct;

BE IT RESOLVED, that the incoming administration is requested to share the apprehension of the delegation from Fulton County Medical Society over the rising trend of deviation from the accepted Code of Medical Ethics and make a vigorous effort to set machinery in motion to bring such deviations to the attention of the members of this Society with the end in view of reversing this trend.

Reference Committee recommendation—The Committee recommended that any specific cases of misconduct by members of the Medical Association of Georgia be transmitted to the Committee on Professional Conduct. The Committee also recommended that a copy of the Principles of Medical Ethics of the American Medical Association be provided each member of the Medical Association of Georgia and that each new member be provided with a copy of this booklet upon being elected to the Medical Association of Georgia.

House of Delegates action—recommended that the Reference Committee recommendation be adopted after ensuing discussion, and the motion carried.

Resolution on Rotary Power Lawn Mowers

Fred G. Hodgson

RESOLVED, that in the light of the increasing number of injuries, due to the rotary type of power lawn mower, that have come under our care and the disastrous results of these injuries that The Medical Association of Georgia be requested to take appropriate action to investigate means of preventing this type of maiming injury.

Reference Committee recommendation—The committee recommended that it be referred back to the Department of Public Health of the State of Georgia, as we feel that the Industrial Hygiene Section of that department should be better qualified than we to make the appropriate recommendations.

House of Delegates action—recommended that the reference committee action on the Resolution on Rotary Power Lawn Mowers be adopted and the motion carried.

It was moved and seconded that the Report of Reference Committee No. 4 be adopted as a whole, and after some discussion the motion carried.

REPORT OF REFERENCE COMMITTEE NO. 5

J. M. Byne, Chairman

The following reports as presented to this Committee are printed in full with the Reference Committee's recommendation and the action pursuant to it by the House of Delegates.

Report of Secretary

David Henry Poer

Since emphasis this year is being placed by the Association on brevity and conciseness, many details will not be included in this report, particularly those that would be duplicated in the reports of other officers and committee chairmen. However, a few important points are worthy of repetition, and first of these is the tremendous increase in activity in many phases of Association work, plus an increase in membership to the highest number in its 104 years of existence (2,537). Most of this progress has been done in the face of the usual small few who complain that "you are spending too much money," "we never did that before," "let's wait for another few years before deciding," and many similar comments, but by and large, this office has had the enthusiastic cooperation of more than 90 per cent of our members.

Office and Personnel: The increased volume of work being carried on by the executive staff of the Association requires more office space, and negotiations are now under way with the Fulton County Medical Society for one large office room to be used primarily for conferences and to display some of the valuable historical files of the Association. We hope to place pictures of all past-presidents on the walls of this room.

On November 1, 1953 it was necessary to make a change in Executive Secretaries and in the few months since taking charge Mr. Milton Krueger has made excellent progress in assuming and expanding the responsibilities of that office. Mr. John Kiser came into the office on October 1 and has published an excellent *Journal* and at the same time assisted with many other administrative duties. With the employment of Miss Frances Porcher, Mr. Kiser will give more time to Association matters along with Mr. Krueger. These men plan to visit all county societies, carrying the program of the Association to the grass-roots level and this will require considerably more travel than has previously been necessary. The work of Miss Franklin as bookkeeper has been immensely satisfactory and will be described in more detail in the Treasurer's Report. Mrs. Mulligan continues to do an excellent job as general secretary for the office.

Assistant Secretary-Treasurer: In June 1953, Dr. Mark Dougherty came into the office as Assistant Secretary-Treasurer and gave invaluable help up until January 1 when he asked to be relieved. With the constant increase in the duties of this office, such assistance is badly needed and should be continued.

Recommendations: That no changes be made in executive personnel and plans described above for additional space be completed.

District Societies: These organizations carry on as in the past with improvements in some and a discouraging "status quo" in others. The Ninth District has an excellent organization, including the publication of a newsy bulletin and this results from the vigorous activity of their secretary (George T. Nicholson) and his helpful wife. Actually most of the weakness of district society organization can be charged to untrained and poorly instructed secretaries, who receive too little assistance and cooperation in carrying on their duties. Many societies now charge regular dues to cover secretarial expenses and some of the local entertainment costs to protect the small county societies, but these dues should be kept at a low minimum rate. Excellent speakers for scientific programs are readily available and this office stands ready to help whenever called upon.

Recommendations: That attendance at District Society meetings be stimulated through a closer liaison with County Medical Societies.

County Societies: It is felt that these units constitute the real strength of the Association, and it is planned to visit and counsel with each of the larger ones during the coming year. Officers of county societies are requested to give the Executive Secretary adequate time on their programs for him to explain some of the more important plans and policies of the Association. They will find him ready to enlist the facilities of this office in giving all the assistance that they desire to carry on a progressive program.

Requests have been made to form new societies in areas with few physicians and these have been discouraged in favor of affiliation with nearby larger societies. In several locations small societies have disbanded except for an annual business meeting,

with residual members affiliating with adjoining societies to mutual advantage. It is believed that at least 15 members are necessary to provide the nucleus of an efficient organization for administrative purposes.

Recommendations: That members of very small and inactive county societies be encouraged to join nearby and adjacent county societies, and that new societies with less than 15 members be discouraged.

Council: As evidenced by the attendance record, interest and activity of Council has been at the highest level of its history. This means that all Councilors are familiar with the affairs of the Association and are actively entering into management. Likewise many Vice-Councilors have attended meetings of Council and evidenced great interest in Association problems. However, since Vice-Councilors have no vote and regular Councilors can now be depended upon to carry out their duties, it is my opinion that these busy physicians should not be called upon to give their time when it is neither needed nor used.

Recommendations: That Vice Councilors be discontinued as officers of the Association.

Executive Committee: More and more has it become necessary for this office to call upon this group for decisions regarding important plans and policies of the Association. Following the recommendation made by Past-President Holton and President-Elect Wright this committee should be enlarged to include the immediate Past-President, the President-Elect and Chairman of Council in addition to the present members (President, Secretary-Treasurer and two members of Council). It is also recommended that the Executive Committee meet once a month if necessary.

Recommendations: New members of Executive Committee—see above.

House of Delegates: For the first time in history, the House changed the system of presiding officers in 1953 and was presided over by a Speaker. The two meetings in Savannah were well attended and discussions were lively, indicating much increase in interest by the members.

Recommendations: That the Speaker and Vice Speaker be included as officers of the Association and elected in the same manner. For efficiency their term of office should be two years with limitation of re-election to one time.

Committee Activity: About three fourths of the committees have been active even though some were slow in beginning their work. A serious study of committee work has brought out the important point that members, particularly the chairman, should not be changed annually, or at least for several years. The most effective work is carried on by those committees that carry on from year to year, and with chairmen who know how to take on an assignment and carry it to successful fruition.

There has been little activity of one important committee, namely, the Committee on American Medical Education Foundation, and it is felt that means must be found to raise funds for this highly

important purpose. However, each county and district society has a responsibility to see that each member does his duty in this regard, or else none of us will have any comeback when medical schools turn to the federal government for financial assistance that must be forthcoming from somewhere.

Recommendations: That active committees be kept intact, and that the AMEF Committee be activated.

Annual Session: These meetings increase in size each year and there has been marked improvement of the program and exhibits. Much credit is due the specialty societies for providing outstanding speakers of national importance. The number of commercial exhibits increases each year as well as the interest of our members in their displays. No doctor needs to be told, I am sure, that the fees paid by these friends of the profession pay most of the expenses of the Annual Session.

Recommendations: That one day of Annual Session be devoted to a program arranged especially for General Practitioners.

Woman's Auxiliary and Better Health Council: These two important auxiliary groups can be considered together because of similarity of relationship with the Association. The few health conferences that have been held were interesting and valuable, but many more of them are needed. Attendance at health forums, with or without radio and television indicates a real interest in such matters by the public if the right methods to organize them can be found.

Unfortunately, the Woman's Auxiliary did not publish a report of last year's activities for study, but it is known that it provides a sympathetic right hand to all the activities of our Association. Perhaps if a more definite program could be requested of them, they would willingly carry on such assignments to the mutual advantage of both organizations.

Recommendations: That financial assistance and cooperation with these organizations be continued.

Professional Conduct and Ethics: During the year several problems concerned both with professional and non-professional activities of physician members of the Association have arisen. These are not to be confused with the increasing number of grievances that come from patients which usually concern excessive fees, and inadequate medical care. Disciplinary action by local societies has been required and this has brought to attention the need for each society to have a constitution and by-laws easily available for reference, and an official copy of the minutes of all business meetings. It is always desirable to settle these controversies on a local level, but the accused must be told that he has the right to appeal to the Mediation Committee of the Association and final review by the Council.

The number of malpractice suits involving both doctors and hospitals has increased which should impress each member with the necessity of adequate insurance coverage for this purpose. It has been estimated that more than 50 per cent of our members do not carry insurance of this type which seems alarming. Up to now the record of our legal counsel

has been exceptionally good in handling those cases where his assistance has been requested, with many suits dismissed and others settled for small amounts. All members when threatened with legal action should notify this office directly and promptly and also should not discuss details with anyone. Any insurance company with a policy covering a member should be requested to consult with our legal counsel, and to make no settlements without his approval. A settlement on a nuisance basis by one company becomes a precedent for each and every one of us to face as a potential defendant.

A problem concerning medical ethics continues to crop up, and this one concerns ownership by a physician member in a drug store, medical supply company, re-packaging pharmaceutical firms and similar business organizations. If the customers of such a business are also the patients of the physician-owners, then the problem of his business income might be interpreted as a rebate or kick-back under some circumstances. It is believed that some of our members have become involved in such a situation innocently and without full appreciation of the implications that have arisen. More information concerning this problem should be given to all members with recommendations concerning the proper method of management of such business interest.

Recommendations: That all county societies adopt and keep an active constitution and by-laws and minutes-book in the office of their Secretary at all times, and that physicians owning stock and interest in any business supplying the medical needs of his patients be advised to conform to the ethics of this Association which are identical with those of the American Medical Association.

Reference Committee recommendation—The Committee approves the Secretary's report with the exception of the following changes.

(1) delete last clause in recommendations to county societies which reads 'and that new societies with less than 15 members be discouraged.'

(2) recommend that Vice-Councilors continue as officers of the Association.

(3) recommend that the Executive Committee of Council include past president, president-elect, president, secretary-treasurer, the chairman of Council and one other member of Council. When separation of the office of secretary-treasurer into two offices becomes association policy this will give a total of seven members.

(4) Oppose recommendation that one day of the Annual Session program be devoted to General Practitioners since it appears to the Committee that many papers of interest to the General Practitioner are included in the present program. (In ensuing discussion it was brought out that this decision is up to the Scientific Work Committee and as such is only a recommendation.)

House of Delegates action—recommended that the Secretary's report and the Reference Committee action be adopted and the motion carried.

Report of Treasurer

David Henry Poer

Changing the fiscal year to run from January 1 through December 31 to conform with the financial policies of the American Medical Association has necessarily caused some difficulties in making accurate comparisons. Marked increase in activities of

the Association necessitated an assessment for dues this year of \$25.00 and our income for 1954 is estimated to be \$73,500.00.

In keeping with these figures, the Committee on Audits and Appropriations of Council has prepared a budget which was approved by Council and was put into effect on January 1, 1954. Following an increase in dues some uncertainty always exists concerning any possible resignations but the reverse has usually been true. However, it will be impossible to determine these figures until after December 31 of this year, and make a budget corresponding to our income for 1955.

Remarks have been heard during this past year concerning "deficit spending" and the use of our financial reserves to pay current expenses, but I can assure you that neither has taken place. Also, anyone sufficiently interested is invited to contact our auditors (Ernst & Ernst) and review the accounts for themselves. At the same time they are invited to give any worthwhile suggestions concerning any possible methods of saving money.

The recommendation with which I am in hearty accord has been made to Council that a separate Treasurer be provided for the Association. While working on the revised Constitution and By-Laws in 1948, I first made this recommendation and know that it is the plan used in most of the other states.

Health and hospital insurance and pension plans for employees of the Association: As the most potent method of combating socialized medicine, all persons are advised to keep in force a good hospital and health policy (Blue Cross—Blue Shield), but the present salary range paid our employees does not permit this. To carry out our own suggestions to the public, I recommend the coverage of our present staff with Blue Shield and Blue Cross coverage (estimated cost \$227.40).

Also, a serious problem in this office has been the constant turn-over in personnel, which means that valuable time and money is always lost. Practically all well organized business firms now have a pension plan in force which promotes permanency and stability amongst its executive staff.

The term of office of your present Secretary-Treasurer expires this year. If your next Secretary-Treasurer is required to spend as much time in administering the affairs of the Association, he should be paid a salary or given an allowance commensurate with the time required. No doctor should be expected to make this sacrifice without fair compensation.

Recommendations:

1. Discontinue 40 years of active membership as basis for Life Membership.

2. Change Constitution to provide for Treasurer as a separate officer.

3. Provide Blue Cross—Blue Shield coverage for all lay employees of the Association (full time).

4. Request Council to study Pension Plan for employees with recommendation that such be put in force if and when funds are available.

Statement of Assets and Liabilities—By Funds
(See Auditor's Report, page), this issue.)

Statement of Income and Expense—By Funds
(See Auditor's Report, page), this issue.)

Tentative Budget for 1954

INCOME					
Income from Dues—(1900 active members)	\$47,500.00				
Journal Advertising	18,500.00				
Fees from Exhibitors Annual Session	5,500.00				
Interest and AMA Service	2,000.00				
	<u>\$73,500.00</u>				
DISBURSEMENTS					
1. Salaries	\$22,200.00				
2. Fixed Allotments					
Pension Payments	\$ 1,800.00				
Honorarium—President	1,000.00				
Attorneys Retainer Fee	1,200.00				
Annual Audit	600.00				
Cont. Fulton Co. Medical Society	1,500.00				
Insurance & Bonds for Personnel	200.00				
Woman's Auxiliary	850.00				
Better Health Council	1,200.00	\$ 8,350.00			
3. Journal Publication					
Engraving and cuts	\$ 600.00				
Editorial Assistance	100.00				
Stationery	300.00				
Postage	500.00				
Clipping Service	200.00				
Addressograph and Supplies	150.00				
Copyright	50.00				
Printing	18,750.00	\$20,650.00			
4. Headquarters Expense					
Travel	\$ 2,600.00				
Meetings (Council controlled)			500.00		
Stationery and Printing			2,000.00		
Postage			800.00		
Telephone and Telegraph			1,200.00		
Depreciation			500.00		
Office Supplies and Expense			475.00		
Dues and Subscriptions			250.00		
Janitor Service			260.00		
Payroll Tax			200.00		
Sundry			300.00	\$ 9,085.00	
5. Annual Meeting Expense			\$ 6,000.00	\$ 6,000.00	
6. Committee Expense					
1. Rural Health			\$ 200.00		
2. Medical Defense			600.00		
3. Legislation			500.00		
4. Maternal Welfare			150.00		
5. Industrial Health			100.00		
6. Public Relations			1,000.00		
7. Insurance and Economics			1,000.00		
8. Committee on Awards			200.00		
9. A.M.E.F.			250.00		
10. Veterans Affairs			200.00		
11. Committee on Hospitals			100.00	\$ 4,300.00	
7. New Equipment					
Machines			\$ 175.00		
Filing Cabinet			50.00		
Desk			125.00	\$ 350.00	
Total Disbursements				\$70,935.00	
Contingent Fund				\$ 2,565.00	

Comparative Statement of Assets and Liabilities
(Accrual Basis)

THE MEDICAL ASSOCIATION OF GEORGIA
March 31, 1952, and March 31, 1953

	General Fund	Benevolent and Building Funds	Abner W. Calhoun Lectureship Fund	Mar. 31, 1952	Mar. 31, 1953	Increase Decrease*
ASSETS						
Cash	\$52,773.23	\$ —	\$ 202.44	\$52,975.67	\$33,967.46	\$19,008.21*
Securities owned	—	63,320.00	5,535.50	68,855.50	68,855.50	—
Accounts receivable	3,978.35	—	—	3,978.35	1,933.27	2,045.08*
Office furniture and equipment	3,389.68	—	—	3,389.68	2,840.33	549.35*
Prepaid annual meeting expense	—	—	—	—	1,015.00	1,015.00
TOTAL ASSETS	\$60,141.26	\$63,320.00	\$ 5,737.94	\$129,199.20	\$108,611.56	\$20,587.64*
LIABILITIES						
Accounts payable—A.M.A.	\$ 4,087.50	\$ —	\$ —	\$ 4,087.50	\$ —	\$ 4,087.50*
—Other	2,095.06	—	200.00	2,295.06	633.05	1,662.01*
Withholding and pay roll taxes	665.77	—	—	665.77	883.95	218.18
Deferred income:						
Membership dues	11,887.50	—	—	11,887.50	11,328.75	558.75*
Unearned subscriptions to The Journal	5,943.75	—	—	5,943.75	5,802.56	141.19*
Exhibitors fees—1952 annual meeting	8,975.00	—	—	8,975.00	5,480.00	3,495.00*
TOTAL LIABILITIES	\$33,654.58	\$ —	\$ 200.00	\$33,854.58	\$24,128.31	\$ 9,726.27*
EXCESS OF ASSETS OVER LIABILITIES	\$26,486.68	\$63,320.00	\$ 5,537.94	\$95,344.62	\$84,483.25	\$10,861.37*

(Furnished by Ernst & Ernst — April 30, 1954)

ERNST & ERNST

Accountants and Auditors, System Service
First National Bank Bldg., Atlanta

April 30, 1954

Dr. David Henry Poer
Secretary-Treasurer
The Medical Association of Georgia
Atlanta, Georgia
Dear Doctor Poer:

In reply to your recent query, on comparable bases, the total assets of The Association decreased \$20,587.64 as between March 31, 1952, and March 31, 1953, while the total liabilities decreased \$9,726.27. This resulted in a decrease in net assets as between the dates mentioned of \$10,861.37. This latter figure is, of course, the net deficit for the year in question, as shown by the statement of income and expense included in our report as at March 31, 1953.

The balance sheet included in our report for the year 1952 was on a strictly cash basis, whereas the balance sheet in our report for the year 1953 was on an accrual basis.

Based on a copy of The Association's budget for the year 1953 which was furnished us, the anticipated excess of disbursements over income was \$14,920.32, whereas the net deficit, as mentioned above actually amounted to \$10,861.37. All of the decrease in net assets is applicable to the general fund, as there was practically no change* in the assets of the reserve funds, viz., benevolent and building and lectureship funds.

Yours very truly,

/s/

J. S. MITCHELL

P. S.—In further answer to you, actual salaries paid for the year ended March 31, 1953 amounted to \$22,262.02, whereas the budgeted salaries for the year ended December 31, 1954 are \$22,200.00. From this it will be seen that the budgeted salaries are \$62.02 less than the salaries paid for the year ended March 31, 1953.

J. S. M.

*Change in reserve fund was increase of \$24.19.

NOTE: From the net decrease in assets (\$10,861.37) should be subtracted the \$10,000.00 donation to the American Medical Education Foundation.

Reference Committee recommendation—The committee approves the report of the Treasurer and makes the following recommendation.

(1) Suggests 50 years of active membership or retirement as a basis for life membership. (Must be sent to Constitution and By-Laws Committee for any recommended action.)

(2) Make necessary changes in Constitution to provide for treasurer as separate officer of the Association.

(3) Opposes Blue Cross-Blue Shield coverage for all full time lay employees of the Association until such a time as there are sufficient funds to permit this action.

House of Delegates action—recommended that the report of the Treasurer and the reference committee action be adopted and the motion carried.

Ninth District Councilor's Report

W. B. Schaefer

The report from your Councilor in the Ninth District shows much activity during the year of 1954.

District meetings have been held twice a year and have been well attended by both the Doctors and their wives. Each medical society in the district has been having periodic meetings with scientific and social hours. Several counties have combined for the scientific meetings. Stephens and Habersham counties alternate the different meetings in the two counties each month.

We have an increase in membership due to the establishment of new doctors in the area, particularly in the Gainesville area and other Hill-Burton hospital areas.

The Ninth District is putting out a monthly paper or newsletter to each member through the efforts of our very able secretary, Dr. George Nicholson, Cornelia, Georgia. All active members are members of the M.A.G. and A.M.A. The next meeting of the Ninth District Medical Society will be held April 21st at Jasper, Georgia.

Ninth District Membership

Counties	Members Dec. 31, 1953		Members Dec. 31, 1952	
	MAG	AMA	MAG	AMA
Banks	1	1	1	1
Blue Ridge	11	8	10	9
Cherokee-Pickens	13	9	11	7
Forsyth	5	4	5	4
Gwinnett	10	3	10	3
Habersham	17	15	15	10
Hall	33	24	33	26
Jackson-Barrow	17	12	16	11
Rabun	3	3	3	3
Stephens	12	10	11	8
Total	122	89	115	82

Reference Committee recommendation—The Committee approves the report of the Ninth District Councilor and it was so voted.

House of Delegates action—recommended the adoption of the report of the Ninth District Councilor and the motion carried.

Tenth District Councilor's Report

Harry L. Cheves

The Tenth District Medical Society has had two excellent meetings which were well attended.

Very little progress has been made in combining of the small county medical societies. They oppose this because they will lose a delegate to the state meetings.

Increase in membership in the state organization as well as in the A.M.A. has been very gratifying. The chart below will show the status by counties.

Tenth District Membership

Counties	Members Dec. 31, 1953		Members Dec. 31, 1952	
	MAG	AMA	MAG	AMA
Clarke-Madison-Oconee	41	34	42	34
Columbia	—	—	—	—
Elbert	16	6	15	10
Franklin	6	4	6	3
Greene	1	1	2	2
Hart	6	4	4	4
McDuffie	6	6	5	5

Morgan	5	2	5	2
Richmond	184	143	147	128
Walton	9	8	8	8
Warren	2	2	2	2
Wilkes	16	10	14	7
Total	292	220	252	206

Reference Committee recommendation—The Committee approves the report of the Tenth District Councilor and it was so voted.

House of Delegates action—recommended the adoption of the report of the Tenth District Councilor and the motion was carried.

Report of the Committee on Scientific Work

H. Ansley Seaman, Chairman

By custom a copy of the Scientific Program is submitted each year as the report of this committee without comment and it is with pride that we follow this procedure. (See *Journal* of the MAG 43:293-317 (April) 1954). However, even a casual study will reveal momentous changes in its size and scope which now makes the work of this committee "big business", requiring careful planning and organization a year or even more in advance. Taking cognizance of this important transition, it seems timely for the committee this year to enlarge its report and to make certain recommendations intended to improve the efficiency of its work.

The plan instituted at the 1952 Annual Session of requesting the organized specialty societies to assist with or actually prepare the programs for the sections has been followed this year. We feel that it has many advantages, the chief of which is the fact that each group invites and pays the expenses of an outstanding guest speaker. Also, greater interest in the section programs has resulted in increased attendance. The chief disadvantage has been the fact that some of the groups are not well organized and it has been difficult to find any one person or committee with authority to act for the section. An attempt to correct this has been made this year by requesting each section to designate a program chairman to work with this committee in setting up the program for 1955.

Recommendations:

1. That each section elect or designate a representative each year to serve as a member of an advisory committee to the Committee on Scientific Work in the preparation of the program for the Annual Session. This representative may be the secretary or an officer of the special group that he represents.

2. Bearing in mind the fact that the majority of members of the MAG are general practitioners the committee feels that special efforts should be made in 1955 to prepare a program that will meet their particular needs and desires. To this end it is our recommendation that one day be set aside for a program for general practitioners only, and that the Georgia Chapter of the American Academy of GP through its officers be requested to assume the responsibility for the details of such a program. On

this day no specialty societies will have a part in the official program except such small groups as Anesthesiology, Pathology, Proctology, Neuropsychiatry and Dermatology (less than 50 members).

3. To improve the efficiency of the work of this committee in the headquarters office it is recommended that responsibilities be divided as follows:

Secretary to Committee on Scientific Work: Executive Secretary.

Scientific Papers and Guest Speakers: Secretary of Association.

Commercial Exhibits: Assistant Executive Secretary.

House of Delegates Proceedings (and Hand Book): Associate Editor and Managing Editor.

Local Arrangements Liaison: Executive Secretary.

Ticket Sales: Bookkeeper.

Program: Asst. Exec. Secty. and Editorial Asst.

Scientific Exhibits: Asst. Secty. of Assn. and Asst. Exec. Secty.

Publicity: Asst. Exec. Secty.

4. The final recommendation of this committee is that the new committee, including the Advisory Committee, hold its first meeting during this Annual Session to begin preparations for the 1955 program.

Reference Committee recommendation—The Committee approves the report of the Committee on Scientific Work, with the following changes:

1. Request that sections be specifically listed.

2. Request deletion of the second recommendation in regard to one day being set aside on the program of the Annual Session for general practitioners since this matter was covered adequately in the Report of the Secretary-Treasurer.

House of Delegates action—recommended that the adoption of the report of the Committee on Scientific Work and the motion carried.

History and Vital Statistics Committee Report

J. Calvin Weaver, Chairman

There has been no meeting of the History Committee as it is almost impossible to get such a meeting of the members, who are so scattered over the state. The only thing to report is the fact that I have finished writing the History of Medicine in Georgia under the heading, Georgia as a Province. This brings the Georgia Medical History on through the Revolutionary War and I have now begun the medical history of Georgia as a State. Just when this last portion will be finished is impossible to say, as there is so much material to be worked over and so much research work to be done.

It is useless for me to say again that an official historian should be delegated to do this work and that sufficient funds to carry on the research work and also the publication of the finished history should be provided by the Medical Association of Georgia.

The following is the list read at the Memorial Service of the Georgia physicians who died during the past year.

IN MEMORIAM

ALLEN, Myron B., Houshton, July 20, 1953

BAXTER, J. H., Ashburn, October 13, 1953

BINION, Richard, Milledgeville, October 21, 1953

BOLAND, Frank K., Sr., Atlanta, November 11, 1953
 BROWNING, Zack, Augusta, May 2, 1953
 BRYANS, Charles Iverson, Augusta, July 18, 1953
 BUTLER, Clarence G., Gainesville, November 30, 1953
 CARTER, Curtis Braxton, Columbus, October 6, 1953
 CATRON, Isaac T., Atlanta, December 23, 1953
 COCHRAN, M. F., Newnan, June 17, 1953
 COLEMAN, Y. R., Jonesboro, December 3, 1953
 DANIEL, John W., Savannah, January 1, 1954
 DAVISON, Thomas C., Atlanta, September 17, 1953
 DORMINEY, James Norwood, Cordele, August 2, 1953
 EAVES, B. F. Draketown, April 1, 1953
 FISCHER, Luther C., Atlanta, April 29, 1953
 FLEMING, Albert, Folkston, July 7, 1953
 FORT, Mannie A., Bainbridge, May 9, 1953
 FUTCH, Thomas Allen, Jr., Thomasville, March 20, 1953
 GOODWIN, Henry J., Jr., Douglas, January 27, 1954
 GOOLSBY, Robert Cullen, Sr., Forsyth, February 3, 1954
 HARDMAN, Charles Terrell, Tallulah Falls, October 4, 1953
 HENDRY, Wayland M., Jr., Washington formerly Atlanta, November 16, 1953
 HIGHSMITH, Emmett deWitt, Atlanta, August 11, 1953
 HOGUE, W. L., Villa Rica, January 19, 1954
 HUSON, William Joseph, Covington, June 27, 1953
 IRVIN, I. W., Albany, April 25, 1953
 KING, William Russell Sr., Tennille, December 9, 1953
 LOTT, John J., Broxton, August 8, 1953
 McCORD, Mather Marvin, Rome, December 14, 1953
 McFARLANE, John W., Macon, July 1, 1953
 MILES, William C., Griffin, July 12, 1953
 MOORE, Henry McIntosh, Thomasville, December 29, 1953
 NEVILLE, John C., Register, June 23, 1953
 PATRICK, J. Z., Pulaski, December 28, 1953
 PATTON, Lewis N., Athens, June 24, 1953
 PITTMAN, James Lee, Atlanta, January 21, 1954
 PRICE, William Thomas, Augusta, September 24, 1953
 SMITH, D. D., Swainsboro, March 15, 1953
 SMITH, James M., Cochran, July 31, 1953
 STAMPA, Samuel, Atlanta, November 4, 1953
 STATON, Torrence R., Atlanta, May 7, 1953
 STRICKLER, Cyrus W., Atlanta, July 23, 1953
 TIMMONS, Carl Conrad, Augusta, November 9, 1953
 WHELAN, Edward J., Savannah, July 10, 1953
 YEOMANS, Una Ritch, Jesup, January 10, 1954

Reference Committee recommendation—The Committee approves the report of the History and Vital Statistics Committee and recommends that a budget be submitted as to the amount necessary to provide secretarial and clerical assistance needed to get material in shape and to provide the Executive Committee with the power to act.

House of Delegates action—recommended the adoption of the report of the Committee on History and Vital Statistics and the motion carried.

Rural Health Committee Report

W. W. Turner, Chairman

The Committee Chairman, along with the Secretary and Executive Secretary of the Medical Association of Georgia, attended the Regional Conference on Physicians Placement Service Activities which was held at the Battery Park Hotel, Asheville, North Carolina on September 19, 1953. This meeting was sponsored by Council on Medical Service of the American Medical Association. The conference was attended by representatives from Florida, Georgia,

Kentucky, North Carolina, South Carolina, Virginia and West Virginia. A round table discussion of the activities and questions and suggestions for an adequate State Placement Service Program was held. This meeting was followed by a call meeting of the Committee on Rural Health of the Medical Association of Georgia.

The Chairman of the Rural Health Committee and the Executive Secretary of the Association attended the Regional Rural Health Conference of the Southern States in Birmingham on January 10, 1954. There it was decided that the Rural Health Committee of the State of Georgia sponsor and begin work on a program for determining the needs of communities throughout the state; that efforts be made to interest the physicians of each county in the part they can take in surveying the needs of their prospective counties and the part they can play in providing impetus to a group, who can push and put across an active educational program for general public improvement. This group of interested people must take the lead in promoting a plan for improving general living conditions such as housing, soil conservation, financial savings, hospitalization and medical care insurance, food and nutritional standards as well as availing themselves of the services of the department of Public Health. The first of these meetings was held in Nashville, February 25, 1954 and considerable interest was shown. It is the opinion of the Chairman that slow progress can be made along these lines. If this is possible we will have performed an invaluable service, the harvest of which will be reaped over future years. We must sow that others may reap.

The Chairman attended the National Rural Health Conference in Dallas.

A call meeting of the Rural Health Committee will be arranged around the first of April to further the above idea.

Addendum

The Rural Health Committee (desires to) work with the Better Health Council, the Department of Public Health, the Extension Service of the State and any other group or organization which is dedicated to the task of improving living conditions in the State.

We will work to supply interest, inspiration and initiative to the people of Georgia through a program of education and explanation revealing methods by which persons and communities may help themselves to achieve a better life.

It is believed that the Program of Rural Health cannot be confined to medical problems pertaining to sickness or well-being of an individual or group but that it includes all factors related to or leading to illness or conditions causing illness, such as improper food and clothing, unsanitary living conditions, poor housing, poor soil and farming practices, poor management and a host of related factors.

The basic cause for the existence of many of these factors can be described by three words—ignorance, indifference and poverty. Ignorance, indifference and poverty can only be met through education and example.

It is proposed that our program be presented to the Better Health Council and through this council the important organs of the state be familiarized with the idea, so that they may begin organizing, in the counties and communities, small working groups which will analyze and appraise the needs of the individual community; that a program be presented which will inspire persons and communities to attack their problems of specific need on the home ground; that the Better Health Council be the functioning body of the Rural Health Committee program, and that the physicians of the 159 counties, who are members of the local boards of health, be encouraged to take an active part in this program of Rural Health on a local level.

Reference Committee recommendation—The Committee approves the report of the Rural Health Committee and in the light of this report, commends the Chairman for diligence, interest and work.

House of Delegates action—recommended that the report of the Committee on Rural Health be adopted and the motion carried.

Insurance Board Report

John L. Elliott, Chairman

The cause of prepaid Medical care for the low income groups in Georgia suffered a severe loss when the Chairman of the Committee on Insurance, Dr. W. S. Dorough, found it necessary to decline reappointment.

On June 14, 1953, at the call of the President, Dr. Harbin, members of the committee, met with the officers of the Association and members of Council at the Academy of Medicine in Atlanta for the purpose of re-organization. Certain concepts were agreed upon as basic and fundamental.

(1) Organized Medicine in Georgia must accept the responsibility for, and lead the way in a sincere effort to provide the best possible medical care for all of the people of Georgia at a premium they can afford to pay.

(2) Voluntary insurance plans appear to be the best method so far available of providing medical care for those of our people who are in the low income groups.

(3) These plans and fee schedules should be standardized over the State insofar as is humanly possible.

(4) To accomplish such an ideal it was felt that a board should be set up by the Medical Association of Georgia to co-ordinate such plans. The Board should consist of a physician from each Medical District elected by members of that district to represent them and serve them during their pleasure, and should include laymen not to exceed four, as was originally planned and approved by Council in 1948. Mr. Harold B. Coolidge of Savannah was elected to membership as the first layman and selected as Secretary of the Board.

(5) Complete revision of the schedule of fees should be begun at once. Unlisted procedures and the fees established for them should be listed and additional services added as rapidly as feasible, and as they can be determined to be actuarially sound.

The whole plan was submitted to Council and received its blessing. The President and Council

agreed to select and appoint a member for each Medical District to serve until his successor shall have been elected. This plan will require an amendment to the Constitution and it will be proposed at the meeting of the Medical Association of Georgia in Macon, May 2, 1954.

A Chairman, Co-Chairman, and Secretary were elected, and plans made to meet in Savannah in July or August as soon as the new members could be appointed.

The new Board met in Savannah August 2, 1953, and approved the concepts as outlined. An Executive Committee was elected and given power to act for the Board in the interim between meetings. Plans were made to meet again just prior to the meeting of the Medical Association in May and upon the call of the Chairman.

The Board was ably assisted in its deliberations by Mr. Milton D. Krueger, Executive Secretary of the Medical Association of Georgia, Mr. Lambert Schulze and Mr. Richard Eales representing the Health Council of Insurance companies. Sincere thanks go to these men from all of us.

Pursuant to the decree of the House of Delegates in May 1953, the aggregate family income will be used to limit the service feature, and the income limit will be raised from \$3,600 to \$4,200. The lower limit will remain at \$2,400. Every item in the fee schedule will be checked, revisions being made upward or downward as found to be advisable. Specialty Sections are being requested to give the Board advice and suggestions.

Immediately after the Board meeting the Executive Committee set about the herculean task of revision. Many meetings have been held and hundreds of man hours of labor have been contributed by the members of the Executive Committee, Mr. Krueger, Mr. Schulze, Mr. Eales, and their Companies. At the time of this report Mr. Krueger is submitting the work sheets to the members of the Board for approval. The Executive Committee is recommending that Anesthesia be added; first as an optional, later, we hope, a permanent feature.

The Board wishes to take advantage of this opportunity to express its appreciation to the Officers of the Association and to the members of Council for their kindness and cooperation. We are most grateful for the cooperation of the Physicians of Georgia and the insuring agencies. With such cooperation we feel that the Georgia plan will prove to be a real blessing to the people of Georgia and incidentally to the Physicians of Georgia.

Addendum

WHEREAS, prepaid medical care plans appear to be a prime requisite in Georgia, and

WHEREAS, the Insurance Board of the Medical Association of Georgia must accept the full responsibility for the success or failure of prepaid medical plans in Georgia, and

WHEREAS, the success of such plans depends upon the cooperation of all the practicing physicians of Georgia, and

WHEREAS, thanks to the active participation of our president, William Harbin, Henry Poer, and the

Council, we now have a Board representing all of the Medical Districts in Georgia, and

WHEREAS, that Board in regular session assembled in Savannah, Georgia, August 2, in the year of our Lord 1953, taking full cognizance of its responsibility to the people of Georgia, and the physicians of Georgia and feeling the great need for a more stable organization, approved the proposition of amending the Constitution and By-Laws of the Medical Association to accomplish such stability. Therefore,

BE IT RESOLVED that the Constitution and By-Laws of the Medical Association of Georgia be amended so that section 15, Chapter IX be deleted and replaced by the following words, to wit:

The Insurance Board shall consist of ten physicians in active practice, members of the Medical Association of Georgia, and such lay persons as these ten physicians may elect not to exceed a total of five. One physician and alternate shall be elected by the members of each medical district to serve them during their good pleasure.

It shall be the duty of this Board to formulate and administer all policies and plans pertaining to insurance insofar as such concern members of the Association. In particular it shall sponsor and promote the Georgia Plan including provision for necessary expenses.

Reference Committee recommendation—The Report of the Insurance Board is approved by the Committee, and it was brought to the attention of the Committee that in numerous insurance cases involving Blue Cross-Blue Shield and the Georgia Plan insurance, individuals and families are covered by multiple policies paying benefits far in excess of those normally expected and sometimes enabling the patient to actually reap a profit from an illness or operation. Yet by virtue of contract restricting the doctor to a minimum fee, regardless of circumstances, less than his regular fee. It is recommended that this matter be investigated and adjusted so that the physician in such cases can collect his regular fee.

House of Delegates action—recommended that the report of the Insurance Board be adopted and the motion carried.

Report of A. M. E. F. Committee

E. Van Buren, Chairman

No Report.

Resolution on A. M. E. F. Committee

John W. Turner

BE IT RESOLVED that the House of Delegates take whatever measures might be necessary to activate the Committee on the AMEF, a more active committee cooperating with the purpose of the fund and to secure more active cooperation and work for the intent and purpose of the fund.

Reference Committee recommendation—The Committee approves the reactivation of the AMEF Committee.

House of Delegates action—recommended that the reactivation of the AMEF Committee be adopted as submitted in the resolution and the motion carried.

Report of the Better Health Council of Georgia

Mrs. Bruce Schaefer, Acting Chairman

A former President of The Medical Association of Georgia, realizing the need for a coordinated health program in Georgia, suggested a plan for a State Health Council to a group of 100 leading citizens

of Georgia. As a result of this planning, the Better Health Council of Georgia was organized as a voluntarily supported agency whose purpose is "to promote better health and better health facilities in Georgia; to promote the organization of Regional Health Conferences and local Health Councils." The Better Health Council is the only agency in the State coordinating health activities and extending health information to the grass roots level.

Activities of the Better Health Council

1. Completed 15 radio recordings, participated in by member agencies. These recordings will be rotated to local radio stations throughout the State, with publicity to the press in the localities.

2. Television Programs:

- 1) Forum on School Child Health
- 2) Forum on Tuberculosis
- 3) Forum on Mental Health
- 4) Planning a School Health Program

3. Four regional health conferences have been held which has given the Council the opportunity of contacting 6,500 citizens in 113 counties in the State. Approximately 75 per cent of the attendance represented lay groups.

Private and Public Health physicians, Public Health personnel, and professional and volunteer persons participated in panel discussions at these health conferences. The following health subjects were discussed:

A workshop on School Child Health
Voluntary Health Insurance in Georgia (Medical Prepayment Plan)

Rural and Urban Health in its many phases: environmental sanitation, chronic illness, public health nursing

Infantile Paralysis

Public Health Facilities

Heart Disease

Cancer

Tuberculosis

Red Cross Blood Program

Mental Health

Diabetes

Rabies

Fluoridation of Water

Civil Defense Health Services, Safety, Nutrition

All programs were summarized by showing the need in the community for coordinated effort through a local health council. Below are comments from participants in the regional health conferences:

"... coordinating health activities in a community will mean better health for individuals and the community as a whole."

"... health needs of a community can be met only by real cooperative community action."

"The cooperation of doctors, nurses, dentists... provide the majority of medical service; the voluntary health agencies stimulate public participation in specific problems... The place of the local community health council lies in coordinating the efforts of all of these in a total cooperative effort for better health in all fields."

4. Published a pamphlet on Local Health Community Councils.

5. Assisted in forming 13 new local health councils.

6. Held a Statewide Health Conference in 1952. The workshops of this conference presented recommendations on the following subjects to the Council members for study, planning and accomplishment:

- a) Care of the Chronically Ill
- b) Cost of Hospital Services
- c) Mental Health Facilities in Georgia
- d) Health and Hospital Insurance
- e) Personnel—the need for trained personnel in medicine, nursing, occupational therapy, hospital administration

Dr. F. S. Crockett, Chairman, Committee on Rural Health, American Medical Association, was the principal speaker at the first session of the Statewide meeting. At the conclusion of the conference, he was so impressed with the work of the Council that he suggested that The Medical Association of Georgia should assume full financial responsibility for it.

7. Placed health materials, supplied by member agencies, in each county and regional library in the State.

8. Answered numerous daily requests for literature to assist in organizing local health councils; also supplied health materials to school teachers and students.

9. Co-sponsored two meetings with Medical Association of Georgia, Georgia Hospital Association, Division of Hospital Services, State Department of Public Health, with discussion on 1) Team Nursing; 2) Total Patient Care Utilizing Community Resources.

10. The first quarterly issue of Newsletter was mailed in February.

Future Projects

1. Continuous cycle of regional health conferences in the State. The second regional conferences in the Northeast and Northwest Regions have been held, and plans are being made to hold second conferences in the East Central Region, Swainsboro; Southwest Region, Albany; and Southeast Region, Waycross.

2. A more intensive program of personal contact with local lay groups; also with local health councils, giving assistance to those councils already organized and assisting with the organization of new ones.

3. Placing health pamphlets in the school libraries.

4. Television Forums will be presented as often as gratis time is available.

5. Issuing the quarterly Newsletter which will be mailed to approximately 6,500 citizens in the State.

6. The publication of the first Directory of health agencies and health organizations in the State.

7. Health Legislation.

A Workshop on Local Health Councils—Co-sponsored with The Medical Association of Georgia, the State Department of Public Health and The Better Health Council of Georgia.

Recommendations

1. That the MAG Rural Health Committee and the Better Health Council of Georgia work in a coordinated program on Local and Rural Health Councils.

2. That assistance in the Physicians Placement Program be of major interest to The Better Health Council and its members.

3. That a School Health Committee be appointed by the Medical Association of Georgia to work with the Council on workshops of School Health.

Health Councils

Assistance has been given 13 communities with the organization of local health councils. Some of the projects selected by the local councils are:

1. Securing a physician for the community
2. Securing a dentist for the community
3. Chest X-rays for all school children
4. Placing signs for the public—"No spitting on the Sidewalk", followed with radio and TV programs on health education on the same theme.
5. Hearing and vision programs sponsored in the schools
6. Health Legislation

Five requests for assistance in organizing Health Councils have been received since January, 1954.

A Health Council is a banding together of all voluntary and official health agencies in a community; of professional societies; of civic organizations; and in addition, individuals who, because they represent the public in some special way, can give the health council the points of view of the members of the community who will be served.

In essence, these are the people and organizations who make up a health council and fashion it into a democratic instrument to bring about better health conditions for the entire community.

Reference Committee recommendation—The Committee approves the Report of the Better Health Council and recommends that Project 3 or mass chest x-rays for all school children be abandoned and the question referred to State Public Health Service for their recommendations. The Committee highly commends the Better Health Council for such an elaborate and extensive report on its projects.

House of Delegates action—recommended the adoption of the Report of the Better Health Council and the motion carried.

The Georgia Nutrition Council

Guy V. Rice

The Georgia Nutrition Council was initiated by the Georgia Nutrition Committee in 1949. Through the Council, persons actively engaged in education and research in foods and nutrition, as well as in producing, processing, and serving food, meet and combine and share their efforts, knowledge, and experience to attain the common objective—better foods for better nutrition of the people of Georgia.

Membership is open to any Georgian interested in improving the nutritional status, and thereby the health, of Georgia people. The membership, this year is sixty-two.

There are five sections within the organization. These sections are:

1. Community Nutrition
2. Nutrition in Educational Institutions
3. Food Service
4. Research
5. Food Supply

Through the various projects of these sections, the Council has functioned actively on both State and County levels, attempting to make all the people conscious of nutritional needs and coordinating nu-

trition programs in a number of agencies and associations. Such projects, as the promotion of cornmeal enrichment, combating food fads, classes in nutrition to bring participants up-to-date on the newer knowledge of nutrition and better school lunches for children, have been carried out over the state.

Objectives chosen by the Council for this year, some continued from previous years, are: nutrition education in programs of state and county medical societies, weight control, food fads, packaging and handling of foods, food processing controls, nutrition for the aged, chemical additives and their proper handling, and school lunchroom revision.

The morning session of our annual meeting this year was devoted to a panel discussion on all phases of aging. Participants were a nutritionist, a social worker, and two physicians.

The Georgia Nutrition Council is anxious to extend nutrition education to the general public and to professional organizations. We would like to recommend that each local medical society devote one program during the year to nutrition.

The Council this year is especially interested in food and its relation to the aging process. Our organization is working on a number of other things, among which are combating misleading advertising and food fads, and promoting the enrichment of flour, bread, cornmeal and grits.

We are confident each local community has people who are qualified as nutrition speakers or discussion leaders. The State Health Department has six regional and two local nutrition consultants, and most of the colleges have people trained in nutrition. If, however, they are unable to secure a speaker or discussion leader and would like for us to suggest someone for a particular topic, time and place, we shall be glad to do so.

Enclosed is a list of films especially related to the suggested topics. These films may be secured through your local health department. Among other sources of similar films are the Agricultural Extension Service and The State Department of Education. These films may be obtained through your local county agent, schools or library: Foods as Children See It, Rice and Health, Weight Reduction Through Diet, Why Won't Tommy Eat? and Obesity.

Reference Committee recommendation—The Committee approves the adoption of the report of the Georgia Nutrition Council and commends it for its excellent work.

House of Delegates action—recommended the adoption of the report of the Georgia Nutrition Council and the motion carried.

Resolution on History and Vital Statistics

Jack C. Norris

WHEREAS, for many years the present Chairman of the Committee on History and Vital Statistics has labored faithfully in an effort to compile an accurate history of Georgia medicine; and

WHEREAS, such a history when accurately compiled will contribute greatly to the archives of this Association;

BE IT RESOLVED, that the Council of the Medical Association of Georgia be requested to allocate the sum of not less than \$200.00 to be placed at the disposal of the Committee on History and Vital Statistics for the purpose of promoting this work.

Reference Committee recommendation—The Committee approves the Resolution on History and Vital Statistics and recommends that a budget be submitted as to the amount necessary to provide secretarial and clerical assistance needed to get material in shape and to provide the Executive Committee with power to act.

House of Delegates action—recommended the adoption of the Reference Committee's action on the Resolution on History and Vital Statistics and the motion carried.

It was moved for the adoption of Reference Committee No. 5 report as a whole and duly seconded and the motion carried.

Nomination of Members for State Boards as Required by Georgia Law

Grady Coker, Canton, informed the House of Delegates that no action need be taken in this respect and gave a short talk on the cooperation between Association members and the present Board.

Speaker Goodwin stated that no nominations were necessary for the State Board of Health since these nominations were made in the district societies.

Election of Life Members

This list of eligible life members was read to the House of Delegates by the Executive Secretary and a motion was made for their selection to Life Membership. The motion was seconded and carried.

Bulloch-Candler-Evans County

Daniel, J. W., Claxton
McElveen, J. M., Brooklet

Burke County

Bent, H. F., Midville
Byne, J. M., Waynesboro
Hillis, W. W., Sardis
McCarver, W. C., Vidette
Thompson, C., Waynesboro

Chatham County

Dancy, W. R., Savannah

Fulton County

Adams, H. M. S., Atlanta
Arnold, W. A., Atlanta
Calhoun, F. P., Atlanta
Corley, Frank L., Atlanta
Davis, Jesse E., Atlanta
Funkhouser, W. L., Atlanta
Hodges, Wm. A., Atlanta
Leadingham, R. S., Tennessee
Lunsford, Guy G., Chamblee
Miller, Hal C., Atlanta
Paine, Charles H., Atlanta
Person, W. E., Atlanta
Quillian, Earl, Atlanta
Vinson, C. D., Atlanta

Hancock County

Earl, H. L., Sparta
Jernigan, C. S., Sparta

McDuffie County

Riley, B. F., Thomson

Randolph-Terrell County

Rogers, F. S., Coleman

Richmond County

Kilpatrick, A. J., Augusta
May, Ellis R., Lincolnton
Michel, Henry M., Augusta

Spalding County

Grubbs, J. H., Molena

Telfair County

Born, W. H., McRae

Tift County

Pickett, F. B., Ty Ty

Troup County

Williams, C. O., West Point

Upson County

Garner, J. E., Thomaston

Ware County

Henry, G. T., Barnesville

Speaker Goodwin called for unfinished business and there being none, he called for new business; there being none, Speaker Goodwin asked for a motion to recess the second meeting of the House of Delegates. The motion was made and duly seconded and carried.

Final Session, House of Delegates

(Recessed)

WEDNESDAY, MAY 5, 1954

Speaker Goodwin called the final session of the House of Delegates to Order in the Walter Little Room of the Dempsey Hotel at 2:30 p.m., May 5, 1954. A quorum being present, motions concerning a vote of thanks to the Bibb County Medical Society and their Local Arrangements Com-

mittee, to the City of Macon, the Central of Georgia Railroad, and the Woman's Auxiliary to the Medical Association of Georgia were made and approved.

Speaker Goodwin asked for a motion to adjourn and the motion was made, duly seconded and carried.

Final General Session

WEDNESDAY, MAY 5, 1954

President William Harbin, Rome, called the meeting to order and recognized Mark S. Dougherty, Chairman of the Awards Committee who presented the Medical Association of Georgia Fifty Year Certificates to the following members: W. W. Battey, Augusta; F. Phinzy Calhoun, Atlanta; E. B. Davis, Byromville; Harlan L. Erwin, Dalton; William L. Funkhouser, Atlanta; Rufus E. Graham, Savannah; George F. Hagood, Marietta; William E. Lipscomb, Cumming; Robert V. Martin, Savannah; Ellis R. May, Lincolnton; B. F. Riley, Jr., Thomson; John C. Rollins, College Park; R. J. Westbrook, Ila, and A. G. Wortham, Franklin.

Hoke Wammock, Augusta, presented the Lamar-tine Griffin Hardman Award to Daniel C. Elkin, Atlanta.

Dr. Wammock also presented Certificates of Appreciation from the Medical Association of Georgia to the following three physicians for their outstanding work in the service of the Medical Association of Georgia. Warren Speer Dorrough, Atlanta; John Lawson Elliott, Savannah; Jack Clayton Norris, Atlanta.

Henry Tift, Macon, presented the awards for Scientific Exhibits displayed at the 104th Annual Session of the Medical Association of Georgia;

1st Place—Robert G. Ellison, University of Georgia, "The Use of Preserved Arterial Homografts and Repair of Aortic Aneurysms."

2nd Place—Cardiology Section, Dept. of Internal Medical, Emory University, "Bacterial Endocarditis."

3rd Place—Milford B. Hatcher and Max Mass, Macon, "Cholangiography."

Special Award—Richard Torpin, Augusta, "The Placenta—Variations in Depth of Implantation and Its Relation to Spontaneous Abortion."

Thomas L. Ross, Macon, presented the President's Key to William Harbin, MAG President, 1953-54.

William Harbin then officially presented the President's Gavel to President Peter B. Wright who expressed gratitude for the honor awarded him and pledged his wholehearted support to the Association and membership.

President Peter B. Wright presented William Harbin with the Medical Association of Georgia Certificate of Appreciation for his splendid and untiring

efforts as President of the Association during the past year.

Harry D. Pinson, Richmond County Medical Society President, then issued an invitation to the Medical Association of Georgia to hold the 105th Annual Session in Augusta, Georgia, 1955.

Election results were then announced by Charles H. Richardson, Sr., Chairman of the Tellers Committee:

PRESIDENT-ELECT—H. Dawson Allen, Milledgeville

FIRST VICE-PRESIDENT—Willard R. Golsan, Macon

2ND VICE-PRESIDENT—Milford B. Hatcher, Macon

SECRETARY-TREASURER—David Henry Poer, Atlanta

DELEGATE TO AMA—Eustace H. Allen, Atlanta

ALTERNATE DELEGATE TO AMA—W. R. Dancy, Savannah

DELEGATE TO AMA—Spencer Kirkland, Atlanta

ALTERNATE DELEGATE TO AMA—Henry H. Tift, Macon

COUNCILOR NINTH DISTRICT—Bruce Schaefer, Toccoa

VICE COUNCILOR NINTH DISTRICT—Charles Andrews, Canton

COUNCILOR TENTH DISTRICT—Harry L. Cheves, Union Point

VICE-COUNCILOR TENTH DISTRICT—J. Victor Roule, Augusta

The newly elected officers were installed and the 104th Annual Session of the Medical Association of Georgia was officially adjourned.

Plasma Volume Expander

Veterans Administration has announced the development of a new substance which may be of great life saving value in restoring and maintaining blood volume in patients suffering from severe shock caused by burns, hemorrhage, accidents, gunshot wounds and the like.

Technically known as an expander of blood plasma volume, the new substance shows promise of usefulness in any emergency requiring blood plasma.

Plasma volume expanders are substances which, when injected into the blood stream, increases the volume of circulating plasma and, consequently, also that of the circulating blood. They may, therefore, be of life-saving value in conditions such as hemorrhage, shock and burns, where the plasma and blood volumes become greatly reduced, resulting in collapse of the circulation, if untreated.

The volume restoring action of VA's new substance maintains normal, or more nearly normal, circulation and blood pressure in these conditions.

Since World War Two, such substances have received a great deal of attention by research workers in the hope of finding one that would be effective in clinical use, free from injurious effects and easy to procure, prepare and store indefinitely.

VA's new product in this field is a protein-like substance. It is known scientifically as a "cross-linked glutamyl polypeptide."

Weight for weight, in a test tube, the new material is approximately 10 times more effective in its ability to attract into the blood stream water, or water-like fluids found in the body, than is serum albumin, the chief blood protein which normally maintains blood volume by exerting this effect.

It is stressed that while the new material is known to be considerably more potent than serum albumin in this volume maintaining effect, its precise potency in the blood stream remains to be determined.

With this new substance, tests in animals and preliminary findings in human beings indicate this material causes the desired expansion of plasma volume when injected intravenously.

VA said it remains in circulation in the blood stream for a suitable length of time and it continues to exert its beneficial effect while in the blood stream.

It has been found that after the substance has served its purpose in the blood stream, the body breaks it down and it is then used in part by the tissues as food and in part excreted. Thus far, it has not been observed to cause any adverse effects in the body.

CONSTITUTION *and* BY-LAWS

As revised by the House of Delegates at the 104th Annual Session May 4, 1954.

CONSTITUTION

ARTICLE I.

Name of the Association

The name of this organization is The Medical Association of Georgia.

ARTICLE II.

Purposes of the Association

The purposes of the Association shall be to advance the science of medicine; to promote the interests and uphold the honor of the profession of medicine; to acquire, utilize and disseminate information relative to all diseases and degenerative processes affecting mankind to the end that the people of Georgia may have the most adequate medical care possible; to promote public health, and to foster cordial relations between the members of the medical profession and the general public.

ARTICLE III.

Component Societies

Component societies are those county medical societies which hold charters from the Association or which may hereafter be organized and chartered by the House of Delegates of the Association.

ARTICLE IV.

Composition of the Association

SEC. 1. The Association is composed of members and delegates.

SEC. 2. MEMBERS. The members of the Association are the members of the component county medical societies.

SEC. 3. DELEGATES. Delegates are those members elected in accordance with this Constitution and By-Laws to represent their component county medical societies in the House of Delegates of the Association.

ARTICLE V.

House of Delegates

SEC. 1. POWERS. The legislative body of the Association is the House of Delegates and it shall transact all business of the Association not otherwise specifically provided for in this Constitution and By-Laws.

SEC. 2. COMPOSITION. The House of Delegates is composed of (1) delegates elected by the component county medical societies, (2) the officers and past presidents of the Association and (3) the delegates to the American Medical Association.

ARTICLE VI.

Council

SEC. 1. The Council shall be the Board of Trustees and the Board of Censors of the Association. It shall carry out the mandates and policies as determined by the House of Delegates. The Council shall have full authority and power of the House of Delegates between sessions of that body. The Council shall have charge of all the property and financial affairs of the Association and shall perform such duties as are prescribed by law governing directors of corporations or as may be prescribed in the By-Laws.

SEC. 2. The Council shall consist of the President, the President-Elect, the Secretary-Treasurer and one Councilor from each Congressional District in the State of Georgia.

ARTICLE VII.

Sessions and Meetings

SEC. 1. ANNUAL SESSION. The Association shall hold an annual session during which there shall be general meetings

open to all registered members, delegates and guests.

SEC. 2. TIME AND PLACE. The time and place for holding each annual session shall be fixed by the Council.

SEC. 3. SPECIAL MEETINGS. Special meetings of either the Association or the House of Delegates may be called by a two-third vote of the Council, twenty delegates or upon written petition of one-fourth of the members of the Association.

ARTICLE VIII.

District Societies

In order to promote the best interests of the profession, the House of Delegates shall provide for the division of the State into Councilor Districts, which shall be coextensive with the Congressional Districts in Georgia, and for the organization of all component county societies in the districts into Councilor District Medical Societies.

ARTICLE IX.

Officers

SEC. 1. OFFICERS. The officers of the Association shall be a President, a President-Elect, two Vice-Presidents, a Secretary-Treasurer and one Councilor, and a Vice-Councilor, from each of the Councilor District Societies as provided in the By-Laws. All elections shall be held as prescribed in the By-Laws.

SEC. 2. ELECTION AND ELIGIBILITY. The officers of the Association shall be elected by the members during the annual session. No person shall be eligible to an elective office who has not been a member of the Association for the preceding three years.

SEC. 3. TERMS OF OFFICERS. The President-Elect shall be elected annually. He shall become President on his installation at the close of the next annual session. If the President-Elect be unable to serve, both a President and a President-Elect shall be elected at the appropriate Annual Session. Other officers shall be elected for terms of one year each, except the Secretary-Treasurer and the Councilors who shall serve for three years. One-third of the Councilors shall be elected annually. All officers shall serve until their successors are elected and installed.

ARTICLE X.

Funds and Expenses

Funds for the operation of the Association shall be raised by an equal per capita assessment on the members of each component county medical society. The amount of the assessment shall be set annually by the House of Delegates upon the recommendation of the Council. Funds may also be raised by voluntary contributions, from the Association's publications, and in any other manner approved by the House of Delegates.

The Council shall submit an annual budget to the House of Delegates. The Council shall manage the finances of the Association and shall supervise all funds, investments and expenditures of the Association. All resolutions providing for appropriations, recommended by Council, shall be included in the annual budget, subject to final approval by the House of Delegates.

ARTICLE XI.

Official Publication

The official publication of the Association shall be THE JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA, in which shall be published all official Association notices, abstracts of transactions of the House of Delegates and general meetings of the Association, the annual budget and abstracts of meetings of the Council.

ARTICLE XII.

Seal

The Association shall have a common seal. The power to change or renew the seal shall rest with the House of Delegates.

ARTICLE XIII.

Amendments

The House of Delegates may amend this Constitution by a two-thirds vote of the Delegates present at any annual session, provided that such amendment shall have been presented to the House of Delegates at the previous annual session and that it shall have been published during the year in THE JOURNAL of the Association, or sent officially to each component county society at least two months before the annual session at which final action is to be taken.

BY-LAWS

CHAPTER I.

Membership

SEC. 1. Any physician holding the degree of Doctor of Medicine from a medical college acceptable to the Council of the Association, licensed to practice medicine in the State of Georgia, who has been a citizen of the United States for at least two years and who has not been adjudged guilty of moral turpitude or other serious crime, may be eligible for membership in a component society of the Association.

SEC. 2. The name of a physician recorded on the official roster of a component county society, who has paid the annual dues and assessments of the component county society and of the Association, shall be *prima facie* evidence of membership in the Association.

SEC. 3. Membership in the Association shall be classified as active, associate, honorary, life and scientific.

SEC. 4. ACTIVE MEMBERS. All members shall be active, including the right to vote and hold office, unless otherwise classified by action of the component county society.

SEC. 5. ASSOCIATE MEMBERS. Any physician who is not engaged in the regular practice of medicine for any one of the following reasons, namely: (1) during organized periods of hospital training and graduate education, (2) during periods of service in the Armed Forces, (3) after retirement or (4) for whom the payment of dues would constitute a hardship, may be classified by the component county society as an associate member. Associate Members shall be entitled to all the rights and privileges of the Association except that they shall not pay dues or receive THE JOURNAL without subscription thereto.

SEC. 6. HONORARY MEMBERS. Eminent physicians and other persons who have distinguished themselves in the science of medicine, or for contributions to human welfare, may be elected to Honorary Membership in the Association by the House of Delegates upon nomination by any component county society and approval of the Committee on Professional Conduct of the Medical Association of Georgia. Such Honorary Members may be issued an appropriate certificate of membership without payment of dues.

SEC. 7. LIFE MEMBER. A Life Membership may be granted by the House of Delegates, upon the recommendation of the component county society, to any physician who has had not less than forty years of active membership in the Association or has passed his seventieth birthday. He shall not be subject to payment of dues.

SEC. 8. SCIENTIFIC MEMBERS. There shall be created a new division of membership to be known as Scientific Membership. The privileges of membership under this classification shall entitle the holder thereof to all phases of the Association's activities pertaining to the study of scientific medicine, and shall include the right to attend all scientific meetings, postgraduate study courses, and scientific sessions of component organizations. Scientific members shall pay no dues and shall not be entitled to vote or hold office. They shall not be entitled to Medical Defense or to receive THE JOURNAL except by regular subscription.

SEC. 9. A physician who is under sentence of expulsion from a component county society, or whose name has been dropped from its roll of members, shall not be entitled to

any of the rights, privileges or benefits of the Association, nor shall he be permitted to take part in any of its proceedings.

SEC. 10. The cause of the failure of a practicing physician to affiliate himself with an available component county society, at any time, shall be ascertained before election to membership.

SEC. 11. Eligible physician members of the State and Federal medical services and full time members of approved medical faculties not engaged in private practice of medicine shall pay half the annual dues of the Association provided similar action has been taken by the component county society.

CHAPTER II.

General Meetings

SEC. 1. The general meetings shall be open to all members and guests who have complied with the registration requirements. These meetings shall be presided over by the President or a Vice-President.

SEC. 2. The program for the general meetings shall be prepared by the Committee on Scientific Work and approved by the executive committee of the Council at least 60 days before the Annual Session of the Association and published in the issue of THE JOURNAL preceding the Annual Session.

SEC. 3. All papers read before the meetings shall become the property of the Association, and shall be deposited with the Secretary-Treasurer immediately after being read. Failure to comply with this and other rules set forth by the Committee on Scientific Work regarding papers, discussions and exhibits shall automatically bar scheduled participation in the scientific sessions in the future from this member for a period not less than five years unless he presents an acceptable excuse.

SEC. 4. Upon invitation of the President any physician may register at a general meeting of the Association as a guest upon presentation of adequate evidence of membership in good standing in a component unit of the American Medical Association.

Distinguished lay persons and physicians may be invited as special guests of the Association by the President or by action of the Council. Privileges of the floor may be extended to guests at the discretion of the presiding officer.

CHAPTER III.

House of Delegates

SEC. 1. The House of Delegates shall meet on the first and last day of the annual session at a time fixed by the Council and at such other times as may be necessary for the transaction of the business of the Association.

SEC. 2. Each component county society shall elect one delegate and a corresponding alternate for each twenty-five members, or fraction thereof, whose dues have been paid by December 31st of the preceding year, provided that each component county society shall be entitled to at least one delegate. It shall be the duty of the President to have the representation of each component county society checked by the Committee on Credentials at the time of the annual session, and to fill such vacancies by appointment. Such temporary appointees shall be members of the component society having the vacancy.

SEC. 3. Forty of the registered members of the House of Delegates shall constitute a quorum. All sessions of the House of Delegates shall be open to the members of the Association, except when in Executive Session.

SEC. 4. The House of Delegates shall be presided over by the Speaker or, in his absence, by the Vice Speaker. In the absence of both, a delegate agreeable to it may preside.

SEC. 5. The Secretary-Treasurer of the Association shall be the Secretary of the House of Delegates or, in his absence, by a delegate appointed by the President. The Executive Secretary may serve in this capacity.

SEC. 6. The following shall be the general Order of Business at all meetings of the House of Delegates: 1. Call to order by the President; 2. Roll Call; 3. Election of Speaker and Speaker pro tem; 4. Reading and adoption of minutes; 5. Reports of officers; 6. Reports of Committees; 7. Unfinished business; 8. New business.

SEC. 7. For the purpose of expediting proceedings the President shall appoint from the members of the House of

Delegates the Reference Committees and other committees considered necessary. Any member of the Association may be appointed to serve on a committee created for a special purpose. Such members who are not members of the House of Delegates shall have the right to present their reports in person and to participate in the debate, but shall not have the right to vote.

SEC. 8. All reports and resolutions shall be referred to the appropriate Reference Committees before action is taken by the House of Delegates.

SEC. 9. The House of Delegates shall nominate members of all Boards required by the Laws of Georgia.

CHAPTER IV.

Council

SEC. V. The Council shall meet on the last day of the annual session of the Association to organize and at intervals of not more than four months apart until the next annual session. Special meetings of the Council may be held on the call of the President or upon request of three members of the Council.

SEC. 2. The Council shall be composed of the President, the President-Elect, Vice-Presidents, Secretary-Treasurer, and one Councilor or Vice-Councilor from each Councilor district. Each Councilor and Vice-Councilor shall be nominated by each district society at the time of its annual meeting. In the event of a vacancy in the office of a Councilor and Vice-Councilor, the vacancy may be filled temporarily by appointment by the President from members of that district society.

SEC. 3. The Council shall set up an Executive Committee composed of the President, Secretary-Treasurer, Chairman of the Council and two other members of the Council. The President shall be the chairman of the Executive Committee. It shall meet not less often than bi-monthly to review the affairs of the Association. The Committee shall make recommendations to the Council and shall carry out such items of business as are referred to it by the Council.

SEC. 4. The Chairman of the Council shall be elected annually at the organization meeting and shall serve one year, or until his successor is elected. He shall preside over its meetings and appoint all necessary committees. A Vice-Chairman shall be elected from among its members. The Secretary-Treasurer of the Association shall be the Secretary of the Council.

SEC. 5. The Council shall be the executive body of the House of Delegates and between sessions shall exercise the powers conferred on the House of Delegates by the Constitution and By-Laws.

SEC. 6. The Council shall be the Board of Censors of the Association. It shall consider all questions involving the right and standing of members, whether in relation to other members, to the component societies or to the Association. Any question of an ethical nature may be brought before the Council by the Committee on Professional Conduct or by any member of the Association. It shall hear and decide all questions of discipline affecting the conduct of members of component societies, on which an appeal is taken from the decision of a component society. Its decision in all cases, including questions regarding membership in the Association, shall be final subject to approval of the House of Delegates.

SEC. 7. Each Councilor shall be organizer, peacemaker and censor for his district. He shall visit each county in his district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession, and to keep in touch with the activities of, and to aid in, the betterment of the component societies in his district. He shall make an annual report of his work, listing all eligible physicians in his district who are not members of a component society and of the condition of the profession of each county in his district at the annual session of the House of Delegates. The Vice-Councilor shall assist the Councilor in the performance of his duties. He becomes a voting member of the Council only in the absence of the Councilor from his district.

SEC. 8. Charters for county and district societies shall be issued on approval of the Council and shall be signed by the President and Secretary-Treasurer of the Association. Upon the recommendation of the Council, the House of Delegates may revoke the charter of any society whose actions are in

conflict with the letter or spirit of this Constitution and By-Laws.

SEC. 9. In sparsely settled sections the Council shall have authority to organize the physicians of two or more counties into societies, to be suitably designated so as to distinguish them from district societies, and these societies, when organized and chartered, shall be entitled to all the rights and privileges provided for component societies until such counties shall be organized separately. A physician residing in a county not having a component society shall be referred to an adjacent component county society by the Council for consideration for membership. Choice of any other component county society by such a physician for membership shall be made only with the full consent of all component societies involved.

SEC. 10. The Council shall provide for and superintend the issuance of all necessary publications of the Association, including proceedings, transactions and memoirs.

SEC. 11. The Chairman of the Council shall appoint from among its members, a committee of three members to be known as the Committee on Auditing and Appropriations, which shall cause to be audited all accounts of the Association. The Council shall propose an annual budget for the fiscal year beginning January 1st after each annual session. This proposed budget shall be prepared by the Committee on Auditing and Appropriations for the consideration of the Council at the last meeting in the last quarter of each year. This budget shall be presented to the House of Delegates for its approval after which it becomes effective. It shall also submit an annual report to the House of Delegates, which shall specify the character of all of its property and shall provide full information concerning the management of all affairs of the Association which the Council is charged to administer.

SEC. 12. The Council shall authorize the payment of all necessary expenses incurred by the officers of the Association in the performance of their duties, except those incurred during the annual session. The Council, also, may authorize a special fund to be made available to the President of the Association, who may expend all or any part of it for the good of the Association without restriction.

SEC. 13. The Council shall appoint, at least six months before the annual session, a committee, consisting of three or more of its members, to be known as the Committee on Arrangements for the annual session. This committee shall appoint a general chairman of a local committee on arrangements, who shall be a member of the component society in which the annual session is to be held. This local Chairman shall appoint, from the members of his county society, the personnel of the local committee on arrangements. The local committee on arrangements shall provide suitable meeting places and shall have general charge of all local arrangements subject to the approval of the Committee on Arrangements for the annual session. All expenditures made by that committee in connection with the annual session must be authorized in advance by the Committee on Auditing and Appropriations of the Council. Immediately after the annual session the Committee on Arrangements of the Council shall forward to the Secretary-Treasurer any accumulated balance. Any deficit created on account of the annual session shall be met by the Council on recommendation of the Committee on Auditing and Appropriations.

SEC. 14. The Council shall by appointment fill any vacancy in office not otherwise provided for which may occur during the interval between annual sessions of the Association. The appointee shall serve until his successor has been elected and installed.

SEC. 15. The Council may appoint an Assistant Secretary-Treasurer or an Executive Secretary—either or both and fix their terms of employment.

SEC. 16. The Council shall determine the employment and salaries of all personnel necessary to conduct the affairs of the Association subject to approval of the House of Delegates.

SEC. 17. The Council shall provide such headquarters for the Association as may be required to conduct its affairs.

SEC. 18. The Council shall have control of all technical exhibits at the annual sessions.

SEC. 19. The Council shall fix the bond of the Secretary-Treasurer and all other necessary personnel of the Association.

SEC. 20. The Council shall have full and complete charge of all public relations of the Association, subject only to the House of Delegates.

CHAPTER V.

Election of Officers

SEC. 1. The President-Elect, Vice-Presidents, Secretary-Treasurer, Councilors and Vice-Councilors shall be elected by ballot by the members of the Association. Nominations for these officers except Councilors and Vice-Councilors shall be made orally as the last order of business at the first meeting on the first day of the scientific session. No nominating or seconding speech shall exceed two minutes. The President shall appoint a Committee of not less than three Tellers immediately after the close of nominations who shall have charge of the election.

SEC. 2. Nominations for Councilors and Vice-Councilors shall be made by each district society at its annual meeting and forwarded by its secretary to the Secretary of the Association not later than 15 days before the annual session. If no nomination is presented by a district society in this manner, nominations for Councilor and Vice-Councilor from such district shall be made from the floor. One third of the Councilors and Vice-Councilors shall be elected annually.

SEC. 3. The Secretary-Treasurer shall have prepared in advance an official ballot. One ballot shall be given to each active voting member when he presents himself to cast his ballot. Such member and no other shall prepare his ballot and shall deposit it at that time in a locked ballot box provided by the Secretary-Treasurer and kept in the custody of the Tellers designated by the President. The key shall be kept by the Chairman of the Tellers.

SEC. 4. Voting shall take place during the hours of the scientific program up to 10:30 A.M. of the last day of the annual session. At that time the Committee of Tellers appointed by the President shall count the ballots and report their findings to the members at the last meeting of the Association. The candidate for President-Elect receiving a majority of the votes shall be declared elected, but if no majority is received on the first ballot, the members present shall select the President-Elect from the two candidates having the highest number of votes by secret ballot. Other officers shall be elected by receiving the highest number of votes on the first ballot.

SEC. 5. Delegates and Alternates to the American Medical Association shall be elected in the same manner and at the same time and in accordance with the Constitution and By-Laws of the American Medical Association.

CHAPTER VI.

Duties of Officers

SEC. 1. THE PRESIDENT. The President shall preside at the organization meeting of the House of Delegates and at all meetings of the Association and shall appoint all committees not otherwise provided for. He shall deliver an address at such time during the annual session as may be arranged, and shall perform such other duties as custom and parliamentary usage may require. He shall be the real head of the profession and of the Association in the State during his term of office. So far as practicable he shall visit by appointment the various district societies, and shall assist the Councilors in building up the county societies, and in increasing the prestige of the Association. He shall be a member of the Council and its Executive Committee, and shall be a member of all committees of the Association with the authority to call a meeting of any Committee when necessity demands it or after failure of the chairman to do so. With the consent of the Council he shall terminate any committee whose function has been fulfilled. It shall be his duty with the approval of the Council, to replace any member of any committee who fails to show interest in performing the duties assigned to him.

SEC. 2. THE PRESIDENT-ELECT. The President-Elect shall be a member of the Council, and shall be a member ex-officio of all standing committees. In order to acquaint himself with all the activities of the Association, it shall be his duty to attend all meetings of the Council and the Standing Committees.

SEC. 3. THE VICE-PRESIDENTS. The Vice-Presidents shall assist the President in the discharge of his duties. Upon request or in the absence of the President, the Vice-President will preside over the general meetings of the Association in rotation. In the event of the President's death, resignation, or inability to serve, the Vice-Presidents, in their order shall succeed him for the unexpired term.

SEC. 4. THE SECRETARY-TREASURER. (a) The Secretary-Treasurer or his representative shall attend the general meetings of the Association and the meetings of the House of Delegates, and shall keep minutes of their respective proceedings in separate record books. He shall be Secretary of the Council and its Executive Committee and an ex-officio member of all committees.

SEC. 4. (b) He shall be custodian of all record books and papers belonging to the Association and shall keep account of all funds of the Association which come into his hands. He shall provide for the registration of the members and delegates at the annual session. He shall, with the cooperation of the secretaries of the component societies, keep a card-index register of all the legal practitioners of the State by counties, noting on each his status in relation to his county society, and shall transmit a copy of this list to the American Medical Association, transmitting to its secretary each month a report containing the names of new members and the names of those dropped from the membership roster during the preceding month. He shall conduct the official correspondence, notifying members of meetings, officers of their election and committees of their appointment and duties. He shall employ such assistants as may be ordered by the Council and shall supply all component societies with the necessary blanks for making their annual reports, and shall collect the regular per capita assessments from the component societies. The amount of his salary shall be fixed by the Council.

SEC. 4. (c) He shall give bond in the amount of a sum to be fixed by the Council. He shall receive all funds of the Association, together with bequests and donations. He shall pay money out of the treasury only on authorization of the Council; he shall furnish a balance sheet to the Council at the last meeting of the fiscal year at the annual session of the Association. This shall consist of an itemized statement of all financial transactions of the past year, all accounts made, money received and disbursed with vouchers attached. The fiscal year includes the period of time between January 1st and December 31st. This financial report shall be published in THE JOURNAL as soon as practicable after the end of each fiscal year.

CHAPTER VII.

Component County Societies and District Societies

SEC. 1. COUNTY AND DISTRICT SOCIETIES. All county and district societies now in affiliation with the Medical Association of Georgia or those hereafter organized in this state which have adopted principles of organization in conformity with this Constitution and By-Laws may receive charters from the Association, provided that their constitution and by-laws shall have been submitted to the Council and received its approval. A component society shall consist of three or more active members.

SEC. 2. CHARTER. Upon application to and recommendation by the Council, the House of Delegates shall provide and issue charters to county and district medical societies organized to conform to this Constitution and By-Laws. Such charters shall be signed by the President and the Secretary-Treasurer. The House of Delegates shall have authority to revoke the charter of any component county society or district society whose actions are in conflict with the letter or spirit of this Constitution and By-Laws. Only one component county society shall be chartered in each county.

SEC. 3. NAMES OF SOCIETIES. The name and title of each component county society and district society shall read exactly as found in its charter. No change in such name shall be made without the approval of the Council of The Medical Association of Georgia.

SEC. 4. CUSTODY OF CHARTER. The charter of each component county society and district society as issued by The Medical Association of Georgia, shall be preserved and shall be in the custody of the secretary of such society at all times.

SEC. 5. CONSTITUTIONS AND BY-LAWS. Each component county society and district society shall have a constitution and by-laws. These shall be in conformity with the Constitution and By-Laws of The Medical Association of Georgia, and a copy thereof shall be transmitted to the headquarters of The Medical Association of Georgia for approval and record.

SEC. 6. PURPOSES AND DUTIES. Each component county society shall have general direction of the affairs of the profession in the county and its influence shall be constantly exerted for bettering the scientific, moral and material conditions of its members. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it includes every eligible physician in the county.

SEC. 7. OFFICIAL RECORDS. The official copy of the constitution and by-laws of each component county society shall be kept in a special book provided for that purpose. In it shall be entered all amendments which have been ratified by the Council of The Medical Association of Georgia. It shall contain the signature of each member who is entitled to membership in The Medical Association of Georgia, together with the date of his election, decease, resignation or expulsion. It shall be the duty of the secretary to preserve this book and hold it available when required for reference.

SEC. 8. DELEGATES AND ALTERNATES. Each component county society at its annual meeting shall elect delegates and alternates to represent it in the House of Delegates of the Association in accordance with these By-Laws, unless other definite procedure for the selection of delegates is provided in its constitution and by-laws. The secretary of each component county society shall send a list of such delegates to the Secretary-Treasurer of the Association at least thirty days before the annual session. Representation in the House of Delegates shall be contingent on compliance with these provisions. In the absence of, or the disability or disqualification of a delegate, the vacancy shall be filled by the President from other members of the same component county society.

SEC. 9. COMBINED COUNTIES. The House of Delegates shall have authority to organize the physicians of two or more counties into societies to be designated by hyphenating the names of two or more counties so as to distinguish them from district or other classes of societies. Such societies, when organized and chartered, shall be entitled to all the privileges and representation provided herein for component county societies.

SEC. 10. ANNUAL MEETING. Each component county society shall designate the meeting held nearest to January 1st of each year as its annual meeting, at which time delegates to the House of Delegates, and a local member of the sub-committee on Legislation and sub-committee on Public Health will be chosen, and their names forwarded promptly to the Secretary of the Association.

SEC. 11. PURPOSES AND DUTIES OF DISTRICT SOCIETIES. District Societies shall have one or more meetings during the year. A Councilor and a Vice-Councilor shall be nominated at the appropriate annual meeting and forwarded to the Secretary of the Association to be elected by the Association for terms of three years in a rotating manner with other district societies. At the same time, each shall elect a member to the sub-committees on Legislation and Public Health of the Association.

CHAPTER VIII.

Dues and Assessments

SEC. 1. The annual dues and assessments shall be determined by the House of Delegates upon recommendation of the Council and shall be levied per capita on the members of the Association. They shall be payable on or before January 1st of the year for which they are levied. The secretary of each component county society shall cause to be collected and shall forward to the office of the Association the dues and assessments for its members, together with such data as shall be required for a record of its officers and membership. Any member whose name has not been reported for enrollment and whose dues for the current year have not been reported to the Secretary-Treasurer of the Association on or before April 1st, shall stand suspended until his name is prop-

erly reported and his dues for the current year properly remitted. At no time and under no circumstances shall a member make payment of dues or assessments directly to the Secretary-Treasurer of the Association. Neither shall the Secretary-Treasurer of the Association receive payments of dues or assessments from anyone except the secretary of the component county society or his representative.

An active member who fails to pay dues for one or more years shall be eligible for reinstatement upon payment of dues for the current year plus one year's dues in arrears subject to reapplication and approval by his county society.

SEC. 2. The record of payment of dues and assessments on file in the office of the Association shall be final as to the fact of payment by a member and as to his right to participate in the business and proceedings of the Association and of the House of Delegates.

SEC. 3. For the purpose of medical defense a member shall be deemed in arrears from and during the period extending April 1st of the current year until his dues and assessments shall have been received at the office of the Association, having been remitted by the secretary of the component county society of which he is a member.

SEC. 4. Any county society which fails to make the reports required before the annual session of the Association, shall be held suspended, and none of its members or delegates shall be permitted to participate in any of the proceedings of the Association or of the House of Delegates.

CHAPTER IX.

Standing Committees

SEC. 1. The Standing Committees of the Association shall be as follows:

- (A) Committee on Scientific Work
- (B) Committee on Legislation
- (C) Committee on Medical Education
- (D) Committee on Medical Defense
- (E) Committee on Professional Conduct
- (F) Committee on History and Vital Statistics
- (G) Committee on Public Health
- (H) Committee on Maternal and Infant Welfare
- (I) Committee on Rural Health
- (J) Committee on Industrial Health
- (K) Committee on Public Relations
- (L) Committee on Cancer
- (M) Committee on Insurance
- (N) Committee on Veterans Affairs
- (O) Committee on Constitution & By-Laws
- (P) Committee on Awards
- (Q) Committee on Woman's Auxiliary
- (R) Committee on Hospitals

SEC. 2. Unless otherwise provided in these By-Laws, each of these committees shall consist of three members, each of whom shall serve for three years. One member of each standing committee shall be appointed each year by the President to serve for three or more years as required by each committee and announced at the time of the final meeting of the Association each year. Provided that for the first year the President shall appoint three or more members as required with one member to serve for the necessary graduated period of years to meet these requirements. Failure of a member to carry out the duties of his committee assignment during any year shall automatically cause his removal at the time of the annual session and the President, with the consent of the Council, shall appoint another member to fill his unexpired term. All committees shall make an annual report in writing to the Association headquarters office sixty days in advance of the Annual Session.

(A) THE COMMITTEE ON SCIENTIFIC WORK. The Committee on Scientific Work shall be composed of five members: the President, the Secretary-Treasurer and three members appointed for terms of three years each. The senior appointed member shall serve as chairman. The duties of the Committee on Scientific Work shall be to prepare and publish the Scientific Program of the annual session, subject to the approval of Council. It shall also prepare and publish all rules and regulations governing the selection and presentation of papers, discussions and Scientific Exhibits before

the general meetings and shall present them for publication in *THE JOURNAL* of the Association.

The presentation of Scientific Exhibits for the annual session shall be under the direction of this committee. For this purpose, the committee may set up a sub-committee of three or more members with representatives from the two medical schools of the State.

All lectureships of the Association shall be under the control of this committee, but special sub-committees may be established to advise the committee concerning the selection of proper speakers for each lectureship. These special lectures shall be given before the general meetings at a time selected by the Committee on Scientific Work.

(B) **THE COMMITTEE ON LEGISLATION.** The duties of the Committee on Legislation shall be to represent the Association in securing and enforcing legislation in the interests of public health and of scientific medicine. It shall keep in touch with professional and public opinion, shall endeavor to shape legislation so as to secure the best results for the whole people, and shall strive to organize professional influence so as to promote the general good of the community in local and national affairs. It shall further the education of the general public in health matters fostering a sane point of view about proper medical care.

Each component county society and district society shall designate one member at its annual meeting to serve with the Committee on Legislation in an active capacity. Vacancies in this special sub-committee shall be filled by the President. In addition, the Woman's Auxiliary shall be requested to form a similar committee with representatives from each component auxiliary. The President may appoint for one year an Advisory Committee of any number he deems advisable.

(C) **THE COMMITTEE ON MEDICAL EDUCATION** shall consider and devise means of extending the educational work of the Association for the benefit of its members, working with the component societies wherever possible and serve for the Council on Medical Education of the American Medical Association in this state. All problems relating to the postgraduate study of medicine shall be referred to this committee.

(D) **THE COMMITTEE ON MEDICAL DEFENSE.** The Committee on Medical Defense shall consist of five members, of whom the Chairman of the Council and the Secretary-Treasurer shall be members. The other members, one of whom shall be elected Chairman, shall be elected by the Council for terms of five years each. The duties of this committee shall be to investigate and defend all damage suits brought against the Medical Association of Georgia; to investigate all claims of alleged malpractice made against its members and to take full charge of such cases that are deemed to be worthy of defense; to defend all such cases in the courts of last resort, to furnish General Counsel and pay court costs usual to such litigation, and reasonable fees for local attorneys as shall be arranged by Council. Any member who has indemnity insurance shall have such insurance bear its portion of the expense. However, they shall not pay, or obligate The Medical Association of Georgia to pay any judgment rendered against any member upon the final determination of any case. It shall be empowered to contract with such agents and attorneys as it may deem necessary for the proper carrying out of this By-Law. The assistance for defense, as herein provided, shall be available only to members of The Medical Association of Georgia in good standing.

Any member of the Association threatened with suit for alleged civil malpractice shall immediately communicate with the Secretary-Treasurer of the Association and shall give full and complete information in reference to all the circumstances alleged in the complaint. He shall immediately notify the Chairman of this committee who shall investigate the circumstances reported and shall advise with the attorneys or agents employed by the committee for this purpose. The member sued, or threatened with suit, shall be consulted and shall have the complete confidence of the committee in all transactions connected with the investigation in question. The committee shall have the authority to require of a constituent society or the president thereof, the appointment of a committee of investigation in any such case, and it may direct the committee so appointed to report to the Committee on

Medical Defense and not to the society from which it was appointed.

The Committee on Medical Defense may assist in the prosecution of illegal practitioners in the State of Georgia and assist in the enforcement of the Medical Practice Act of this State.

(E) **THE COMMITTEE ON PROFESSIONAL CONDUCT.** The Committee on Professional Conduct shall consist of the five most recent past presidents of the Association. The senior member shall be Chairman. It shall investigate all complaints relating to or involving the ethical or professional practice of any member of The Medical Association of Georgia. All complaints or accusations against any member of The Medical Association of Georgia relative to irregular practice, excessive fees, habitual failure to respond to calls without adequate reason, extravagant or questionable statements made as witnesses in a court of law, or any act calling for disciplinary measures or investigations of a member, shall become the concern of this Committee. Complaints may be made by an individual patient, physician, board of censors of any local medical society, attorney, or any officer of a regularly constituted court of law. Upon receipt of notice of such complaint, the Committee, through its individual members or some competent person designated by it, shall immediately investigate the charges, and if the Committee is convinced that there is sufficient justification for a hearing the physician shall be requested to appear before at least three members of said Committee to answer charges. Such hearing shall be conducted in private and the source of information and charges will be divulged only at such hearing. No member of this Committee shall sit in a hearing involving a physician from his Councilor District.

After deliberation, the Committee shall have a choice of one of the four following dispositions:

1. Dismiss the case because of insufficient grounds for a legitimate complaint.
2. Attempt a satisfactory adjudication of the complaint.
3. Suggest to the physician changes in his conduct and relationship with his patients, in order that he may not bring unfavorable criticism upon his profession.
4. Refer to the Council of The Medical Association of Georgia all cases in which action by the Council is deemed necessary, together with recommendations as to disciplinary measures to be taken by the Council of The Medical Association of Georgia.

Nothing in this By-Law shall be construed to prevent the selection and active participation in all the functions enumerated above by each component county society.

(F) **THE COMMITTEE ON HISTORY AND VITAL STATISTICS.** It shall be the duty of the Committee on History and Vital Statistics to stimulate and promote the preparation of suitable articles on the history of the Association and its members, and shall recommend their publication to *THE JOURNAL* of the Association. It shall prepare memorials for deceased members, and arrange for their publication. It shall also report to the House of Delegates all new and eligible physicians who were licensed in the State during the past year indicating those who have become members of the Association. The Editor of *THE JOURNAL* and the President of the State Board of Medical Examiners shall be ex-officio members of this committee.

(G) **THE COMMITTEE ON PUBLIC HEALTH.** The Committee on Public Health shall be assisted by a sub-committee of one member elected by each county and district society of the state. Its duty shall be to advise with the Governor and other State officials, and with the Georgia State Board of Health and other related groups in regard to all matters concerning the health of the citizens of Georgia. It shall meet at the time of each session of the Georgia State Legislature with the Committee on Legislation to give assistance in carrying out its duties.

The President may appoint for one year an Advisory Committee of any number he deems advisable.

(H) **THE COMMITTEE ON MATERNAL AND INFANT WELFARE** shall be composed of seven members, three of whom shall be general practitioners. It shall regularly review and analyze the causes of all maternal deaths occurring in the State. It shall investigate conditions affecting maternal care in Georgia and make recommendations concerning improvements thereof. It

shall establish a working liaison with the Georgia State Obstetrical and Gynecological Society and the Georgia Pediatric Society and shall consider the establishment of annual post-graduate regional courses in obstetrics throughout the State with the cooperation of the Committee on Medical Education and Hospitals.

(I) THE COMMITTEE ON RURAL HEALTH shall concern itself with improving medical service in the more sparsely settled areas in the State. It shall be composed of one member from each of the Councilor Districts comprising the Association, in addition to the Director of the State Department of Public Health who shall be a member ex-officio. It shall investigate and make recommendations as to locating and staffing health centers and shall cooperate with the Council on Rural Health of the American Medical Association. The Committee shall designate a member to represent the Medical Association of Georgia at national conferences on rural health.

(J) THE COMMITTEE ON INDUSTRIAL HEALTH shall be composed of five members. The committee shall confer with both labor and management in stressing the importance of preventive rather than curative medicine. It shall investigate and make recommendations concerning the initiation of programs designed to improve safe working conditions for employees and to solve other industrial health problems. It shall cooperate in all respects with the Council on Industrial Health of the American Medical Association.

(K) THE COMMITTEE ON PUBLIC RELATIONS shall be appointed by the President. It shall be the duty of the committee to integrate and publicize all approved plans and projects emanating from the Council and other standing and special committees of the Association. It shall consider all policies and make suggestions and recommendations for improving or changing such policies for the purpose of integration and publicizing. It shall develop additional projects for bettering understanding between physicians and the public.

(L) THE COMMITTEE ON CANCER shall consist of one representative from the Association, one from each of the State-Aid Cancer Clinics, and one each from the Medical Colleges in the State who shall serve not less than three years, and the President shall appoint the chairman from among the members having the longest service. The chairman shall submit a list of physicians' names representing these groups for appointment by the President. An Executive Committee of this committee consisting of not less than six members shall be appointed by the President upon recommendation of the chairman.

It shall be the duty of this committee to represent the members of the Association in dealing with all matters pertaining to cancer, and in particular, it shall advise with the Division of Cancer Control of the Department of Public Health.

(M) THE COMMITTEE ON INSURANCE or Insurance Board shall consist of not less than five members appointed for a period of five years in rotation by the President. The committee may elect one of its members to be chairman or request the President to designate a member as chairman. Members appointed during the first four years shall serve staggered terms as designated by the President.

The four geographical quadrants and the central industrial area shall have representation on this committee. Also the chairman may nominate five lay persons with known interest in the field of insurance for appointment by the President, who shall serve with the Board in an advisory capacity.

It shall be the duty of this committee to formulate and administer all policies and plans pertaining to insurance insofar as such concern members of the Association. In particular it shall sponsor and promote the Georgia Plan including provision for necessary expenses.

(N) THE COMMITTEE ON VETERANS AFFAIRS shall represent the Association in all matters pertaining to all veterans.

(O) THE COMMITTEE ON CONSTITUTION AND BY-LAWS shall recommend to the House of Delegates any amendments which seem to be necessary or advisable. Proposed amendments shall be referred to this committee before action is taken by the House of Delegates.

(P) THE COMMITTEE ON AWARDS shall have complete charge of all awards made by the Association or in the name

of the Association. The decisions of this Committee shall be final in reference to recipients.

(Q) THE COMMITTEE ON THE WOMAN'S AUXILIARY shall cooperate with, advise and direct the Auxiliary in all matters concerning the Association.

(R) THE COMMITTEE ON HOSPITALS shall pursue a continuing study of the relation of the medical profession to the operation of public and voluntary hospitals within this State and shall, when indicated, confer with the State Department of Health, the Georgia Hospital Association and all related organizations and make recommendations to the Association.

CHAPTER X.

Special Committees

Special committees may be created at any time when the necessity arises. Their necessity must be approved by the Council and they shall be appointed by the President.

CHAPTER XI.

The Journal

SEC. 1. THE JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA herein referred to as THE JOURNAL, shall be under the control and direction of the Council. It shall appoint an Editor, and an Editorial Board and make any other provisions for the publication of THE JOURNAL which in its judgment are necessary. Such appointee or appointees shall serve at the pleasure of the Council, which shall have full discretionary power to promulgate rules and regulations governing the publication of THE JOURNAL; enumerate and define the powers and duties of the Editor or Editorial Board, or both; and fix the terms and conditions of their appointment.

SEC. 2. The Council may employ a Business Manager of THE JOURNAL and other personnel and fix the terms of such employment.

SEC. 3. All papers presented before the Annual Session shall be submitted to the Editor for consideration for publication in THE JOURNAL. Abstracts of transactions of the House of Delegates and Council shall be published as early as practicable. Records and notices of component county and district society meetings may also be published, and consideration given to the publication of papers presented before such meetings.

CHAPTER XII.

Rules and Ethics

SEC. 1. The Principles of Ethics of the American Medical Association shall govern the members of this Association.

SEC. 2. The deliberations of the Association shall be conducted in accordance with parliamentary usage contained in the then current edition of Robert's "Rules of Order, Revised," unless contrary to this Constitution and By-Laws.

CHAPTER XIII.

Amendments

These By-Laws may be amended at any Annual Session by a majority vote of the House of Delegates after the amendment has lain on the table for one day.

CHAPTER XIV.

On the adoption of this Constitution and these By-Laws all rules and regulations in conflict herewith are hereby repealed, provided that all officers, delegates and committeemen now in office shall continue their incumbency until their successors are duly elected and installed or chosen as herein provided.

STANDING RULES

1. The Committee on Scientific Work shall prepare the program for all scientific meetings of the Association at all Annual Sessions. It may divide the scientific work into whatever number of sections that seem advisable for the particular Annual Session. It shall appoint temporary officers for all sections until such time as the sections apparently become permanent. As each section becomes established it shall elect its own officers subject to such rules and regulations as may be laid down by the Committee on Scientific Work. The program for all general meetings shall be prepared by the Committee itself. In its work the Committee shall be subject to the approval of the Council and, when necessary, to the House of Delegates.

2. The Executive Committee of the Council shall constitute the publication Committee of THE JOURNAL.

Auditors' Reports

1952-1953

REPORT OF SPECIAL EXAMINATION

THE MEDICAL ASSOCIATION OF GEORGIA — ATLANTA, GEORGIA

March 31, 1952

ERNST & ERNST

Accountants and Auditors, Atlanta

Dr. W. G. Elliott
Chairman of The Council
The Medical Association of Georgia
Cuthbert, Georgia

We have examined the records and files of The Medical Association of Georgia for the year ended March 31, 1952, as maintained in the office of its Secretary and Treasurer. The scope of our examination included a test of the records of cash transactions for six monthly periods, selected by us, by comparisons of the totals of recorded cash receipts with deposits shown by monthly bank statements on file, and by inspection of paid checks, invoices, or other data on file in support of the recorded disbursements. Cash on deposit at March 31, 1952, was reconciled with the amounts reported to us by the depository institutions. We also accounted for the income of the Benevolent and Building Funds and the Abner Wellborn Calhoun Lectureship Fund for the year ended March 31, 1952, and the assets held in those Funds at that date.

A statement of cash receipts and disbursements for the year ended March 31, 1952, and a statement of the assets and liabilities of the several Funds, as at that date, are included herein.

Securities, comprising the entire assets of the Benevolent and Building Funds, are held in safekeeping by the Federal Reserve Bank of Atlanta and were confirmed by direct correspondence.

Assets of the Abner Wellborn Calhoun Lectureship Fund, consisting of cash and securities, were accounted for by direct correspondence with The Citizens and Southern National Bank, Atlanta, Georgia, Trustee.

The amount stated for accounts receivable in the attached Statement of Assets and Liabilities is as shown by a list of these accounts furnished us by employees of The Association. We mailed statements to all debtors for advertising and exhibition space, as shown by the list of these accounts, requesting confirmation of the balances as of March 31, 1952. No material differences have been reported in the replies received to date. The amount for accounts payable represents a listing of unpaid invoices on hand without further verification by us.

Salaries paid employees of The Association are not authorized or mentioned in the minutes of meetings of The Council or House of Delegates, as required by the by-laws of The Association.

A summary of the insurance protection of The Association at March 31, 1952, as determined from policies submitted for our inspection, is presented in this report.

Certified Public Accountants

ERNST & ERNST

Atlanta, Georgia
April 5, 1952

STATEMENT OF CASH RECEIPTS AND DISBURSEMENTS

The Medical Association of Georgia

Year ended March 31, 1952

GENERAL FUND

Cash balance at March 31, 1951..... \$40,177.62

General receipts and disbursements:

Receipts:

Membership dues collected:

Years 1949 & 1950—\$85.00;

year 1951—\$7,684.00.....

\$ 7,769.00

Year 1952

15,850.00

\$23,619.00

American Medical Association for
services, postage, etc.....

434.23

Interest on savings share account

204.87

Sundry

107.30

\$24,365.40

Disbursements:

Salaries paid:

Secretary and Treasurer..... \$ 3,000.00

Executive Secretary 4,150.00

Clerical 3,990.25

\$11,140.25

Less allocations:

Association Journal \$ 3,300.00

Public relations dept.... 2,550.00

5,850.00

\$ 5,290.25

Administrative & other expenses...

11,870.42

Equipment purchased

659.00

17,819.67

\$ 6,545.73

Other receipts and disbursements:

Association Journal:

Advertising receipts \$17,500.42

Subscriptions received 12,013.50

\$29,513.92

Less expenses:

Salaries—allocated \$ 3,300.00

Publication expenses—

as shown by schedule..... 17,991.63

21,291.63

\$ 8,222.29

Annual meeting:

Fees collected from exhibitors.....

\$ 8,975.00

Less expenses of meeting.....

2,418.36

6,556.64

Benevolent and Building Funds:

Interest received — U. S. Savings
bonds

1,250.00

American Medical Association:

Dues collected for remittance—

Note A

\$46,840.50

Amounts remitted

43,003.00

3,837.50

Pay roll taxes and taxes withheld
from employees

\$ 1,781.51

Less payments to Collector of

Internal Revenue

1,182.83

598.68

\$20,465.11

Public relations department:

Salary—allocated portion

\$ 2,550.00

Direct salaries

5,568.00

Expenses—as shown by schedule

4,530.03

Equipment purchased

1,767.20

14,415.23

6,049.88

12,595.61

CASH BALANCE AT

MARCH 31, 1952.....

\$52,773.23

**ABNER WELLBORN CALHOUN
LECTURESHIP FUND**

Cash balance at March 31, 1951.....				\$ 395.30
Receipts—dividends on stocks owned by fund				
			\$ 222.02	
Less disbursements:				
Purchase of 4 shares Atlanta Gas Light, 4½ % preferred stock.....	\$ 404.00			
Fee paid Trustee	10.88	414.88	192.86*	
CASH BALANCE AT MARCH 31, 1952.....				\$ 202.44

NOTE A—According to information furnished by The Association, checks payable directly to the American Medical Association aggregating \$4,900.00 were received and forwarded to that organization during the year ended March 31, 1952, and are not included in the amount shown above.

*Indicates disbursements in excess of receipts.

DETAILS OF EXPENSES

**The Medical Association of Georgia
Year ended March 31, 1952**

ADMINISTRATIVE AND OTHER EXPENSES

Traveling expenses	\$ 2,970.19
Prepayment medical care plans	1,316.31
Medical defense—legal, etc.	1,303.35
Contributions:	
Better Health Council of Georgia	1,000.00
Woman's Auxiliary to The Association	240.77
Fulton County Medical Society	624.73
Stationery and printing	605.29
Pension	600.00
Legal and professional—Audit	540.00
Honorarium to president	500.00
Postage	485.60
Lecture at annual meeting—Dr. D. A. Wright	200.00
Telephone and telegraph	279.50
Public policy and legislation	239.70
Office supplies and expenses	210.67
Insurance and Bond	161.81
Dues and subscriptions	65.00
Janitor service	62.50
Social security tax	33.01
Sundry	431.99
TOTAL	\$11,870.42

PUBLICATION EXPENSES

Printing	\$15,201.07
Cuts of illustrations	923.26
Editorial assistance	700.00
Envelopes	554.61
Critique and corrective service	150.00
Postage	112.98
Clipping service	102.10
Addressograph service and supplies	76.26
Copyright fees	48.00
Social security tax	24.75
Sundry	98.60
TOTAL	\$17,991.63

PUBLIC RELATIONS DEPARTMENT EXPENSES

Press, advice, space, etc., and Macon Conference	\$ 1,619.85
Traveling expenses	894.62
Stationery and office supplies	576.69
Contribution—Fulton County Medical Society	360.00
Telephone and telegraph	336.72
Printing—literature and bulletins	308.70
Postage	298.09
Janitor service	64.00
Social security tax	42.75
Sundry	28.61
TOTAL	\$ 4,530.03

STATEMENT OF ASSETS AND LIABILITIES — BY FUNDS

The Medical Association of Georgia

March 31, 1952

ASSETS	General Fund	Benevolent and Building Fund	Abner W. Calhoun Lectureship Fund	Combined
Cash	\$52,773.23	\$ —	\$ 202.44	\$ 52,975.67
Securities owned	—	63,320.00	5,535.50	68,855.50
Accounts receivable	3,778.35	—	—	3,778.35
Office furniture and equipment—Note A	3,824.62	—	—	3,824.62
TOTAL ASSETS	\$60,376.20	\$63,320.00	\$ 5,737.94	\$129,434.14
LIABILITIES				
Accounts payable:				
Public relations department	\$ 110.09	\$ —	\$ —	\$ 110.09
Woman's auxiliary	10.50	—	—	10.50
General	6,521.80	—	—	6,521.80
TOTAL LIABILITIES	\$ 6,642.39	\$ —	\$ —	\$ 6,642.39
EXCESS OF ASSETS OVER LIABILITIES	\$53,733.81	\$63,320.00	\$ 5,737.94	\$122,791.75

NOTE A—Office furniture and equipment shown above does not include items purchased prior to April 1, 1949.

NOTE B—During the year ended March 31, 1952, \$800.00 was paid from the General Fund which was properly payable from specified funds as follows:

Abner W. Calhoun Lectureship Fund	
(Dr. D. A. Wright—for lecture at annual meeting)	\$200.00
Benevolent Fund—(pension)	600.00
TOTAL	\$800.00

CASH — GENERAL FUND

The Medical Association of Georgia

March 31, 1952

ON DEPOSIT

The Citizens and Southern National Bank, Atlanta, Georgia	\$45,771.32	
Standard Federal Savings and Loan Association, Atlanta, Georgia	6,983.65	\$52,754.97
OFFICE CASH FUND		18.26
TOTAL		\$52,773.23

BENEVOLENT AND BUILDING FUNDS — SECURITIES OWNED

The Medical Association of Georgia

March 31, 1952

	Cost	Face Amount	Redemption Value
UNITED STATES SAVINGS BONDS			
SERIES F			
Due Jan. 1, 1956.....	\$ 7,400.00	\$10,000.00	\$ 8,610.00
Due June 1, 1961.....	5,920.00	8,000.00	6,032.00
SERIES G			
Due July 1, 1957.....	15,000.00	15,000.00	14,370.00
Due Mar. 1, 1959.....	15,000.00	15,000.00	14,235.00
Due Jan. 1, 1960.....	15,000.00	15,000.00	14,205.00
Due Jan. 1, 1962.....	5,000.00	5,000.00	4,810.00
TOTALS	<u>\$63,320.00</u>	<u>\$68,000.00</u>	<u>\$62,262.00</u>
NOTE—The Association has appropriated funds for benevolence and building as follows:			
Benevolence	\$25,000.00		
Building	35,000.00		
TOTAL	<u>\$60,000.00</u>		

ABNER WELLBORN CALHOUN LECTURESHIP FUND

(The Citizens and Southern National Bank, Atlanta, Georgia—Trustee)

The Medical Association of Georgia

Year ended March 31, 1952

	Principal Cash	Income Cash	Combined
CASH HELD BY TRUSTEE			
Balance at March 31, 1951.....	\$ 232.16	\$ 163.14	\$ 395.30
Receipts:			
Dividends received:			
Georgia Power \$6.00 preferred stock.....	—	150.00	150.00
Atlanta Gas Light 4½ % preferred stock.....		72.02	72.02
Transferred to "Principal" from "Income"—Note A.....	206.64	206.64*	—
	<u>\$ 438.80</u>	<u>\$ 178.52</u>	<u>\$ 617.32</u>
Disbursements—Note B:			
Purchase of 4 shares Atlanta Gas Light 4½ % preferred stock	\$ 404.00	\$ —	\$ 404.00
Fee paid Trustee.....	—	10.88	10.88
	<u>\$ 404.00</u>	<u>\$ 10.88</u>	<u>\$ 414.88</u>
BALANCE AT MARCH 31, 1952.....	<u>\$ 34.80</u>	<u>\$ 167.64</u>	<u>\$ 202.44</u>

	Number of Shares	Market Value	Carrying Amount
SECURITIES HELD BY TRUSTEE			
Atlanta Gas Light 4½ % preferred stock.....	19	\$1,919.00	\$1,971.50
Georgia Power \$6.00 preferred stock.....	25	2,875.00	2,849.00
Southwestern Railroad common stock.....	13	975.00	715.00
		<u>\$5,769.00</u>	<u>\$5,535.50</u>
TOTAL CASH SECURITIES AT MARCH 31, 1952.....			<u>\$5,737.94</u>

NOTE A—Under the provisions of the trust indenture, "all unexpended income in the hands of Trustee on July 1st of each year shall be added to the principal of the trust fund.

NOTE B—During the year ended March 31, 1952, a disbursement was made from the General Fund in the amount of \$200.00 to Dr. D. A. Wright for lecture at annual meeting, which was properly payable from the Lectureship Fund.

*Indicates red figures.

ACCOUNTS RECEIVABLE

The Medical Association of Georgia

March 31, 1952

EXHIBITORS AT 1952 ANNUAL MEETING

Baby Development Clinic	\$250.00	
S. H. Camp and Company	250.00	
G. W. Carnrick Company	250.00	
Estes Surgical Supply Company	250.00	
General Electric Company	250.00	
Lanteen Medical Laboratories, Inc.	175.00	
J. A. Majors Company	250.00	
S. E. Massengill Company	250.00	
Nestle Company, Inc.	250.00	
Chas. Pfizer and Company, Inc.	250.00	
Stansell Oxygen Company	250.00	
Surgical Selling Company	250.00	
Testagar and Company, Inc.	250.00	
Van Pelt and Brown, Inc.	250.00	\$3,425.00

FOR ADVERTISING IN ASSOCIATION JOURNAL

Walter W. Ballard Optical Company.....	\$ 15.00	
Dr. P. L. Berezney	10.00	
City View Sanitarium	12.00	
The Coca-Cola Company	29.32	
Eager and Simpson	6.90	
Emory University Hospital	12.00	
Estes Surgical Supply Company	18.00	
Georgia Baptist Hospital	12.00	
Lane-Rexall Drug Stores	17.59	
R. L. Mathis Certified Dairy	10.00	
Crawford W. Long Memorial Hospital.....	12.00	
Marshall and Bell, Inc.	10.00	
The New York Polyclinic Medical School and Hospital.....	18.00	
W. W. Orr Doctors Building.....	17.59	
Peachtree Sanitarium	58.53	
Piedmont Hospital	12.00	
Pineworth, Inc.	18.00	
St. Joseph's Infirmary	12.00	
J. Walter Thompson Company	17.24	
Westbrook Sanitarium	35.18	353.35
TOTAL		<u>\$3,778.35</u>

ACCOUNTS PAYABLE

The Medical Association of Georgia

March 31, 1952

PUBLIC RELATIONS DEPARTMENT

Addressograph—Multigraph Corporation	\$ 5.27	
Cunningham Multigraphing Company	73.13	
International Business Machines Corporation	5.62	
Lane Office Supply Company	1.55	
Southern Bell Telephone and Telegraph Company.....	24.52	\$ 110.09

WOMAN'S AUXILIARY

Addressograph—Multigraph Corporation	10.50
--	-------

GENERAL

American Medical Association	\$4,087.50
Anderson's	16.40
Arcraft Engraving Company	4.34
Atlanta Biltmore Hotel	31.70

Atlanta Linen Service	4.02	
P. H. Collins and Company, Inc.	18.70	
Dunaway, Howard and Embry	300.00	
Franklin Printing and Manufacturing Company	1,371.42	
National Library Bindery Company of Georgia	29.25	
Pay roll taxes and taxes withheld from employees	598.68	
Charles A. Rawson and Associates	17.20	
Southern Bell Telephone and Telegraph Company	41.75	
Western Union Telegraph Company84	\$6,521.80
TOTAL		\$6,642.39

INSURANCE PROTECTION

The Medical Association of Georgia

March 31, 1952

FIRE AND EXTENDED COVERAGE

Contents of building \$ 4,000.00-A

LOSS OR DAMAGE TO PROJECTORS, LOUDSPEAKERS, SCREENS, PUBLIC ADDRESS SYSTEM, ETC.

2,520.00

AUTOMOBILE—(Employees' cars)

Bodily injury 100/300,000.00
Property damage 5,000.00

FIDELITY BONDS

David Henry Poer \$10,000.00
Viola Berry 1,000.00
Sidney Ray Wrightsman, Jr. 1,000.00 12,000.00

NOTE A—Loss payable to Dr. David Henry Poer, Secretary and Treasurer, The Medical Association of Georgia.

REPORT OF EXAMINATION AND SUPPLEMENTARY DATA

THE MEDICAL ASSOCIATION OF GEORGIA — ATLANTA, GEORGIA

March 31, 1953

ERNST & ERNST
Accountants and Auditors
Atlanta

Dr. H. D. Allen
Chairman of The Council
The Medical Association of Georgia
Milledgeville, Georgia

We have examined the records and files of The Medical Association of Georgia for the year ended March 31, 1953, as maintained in the office of its Secretary and Treasurer. The scope of our examination included a test of the records of the cash transactions for the year, by comparisons of the totals of recorded cash receipts with deposits shown by monthly bank statements on file, and by inspection of paid checks, invoices, or other data on file in support of the recorded disbursements. Cash on deposit at March 31, 1953, was reconciled with the amounts reported to us by the depositories. We also accounted for the income of the Benevolent and Building Funds and the Abner Wellborn Calhoun Lectureship Fund for the year ended March 31, 1953, and the assets held in those funds at that date.

A statement of income and expense—by funds for the year ended March 31, 1953, and a statement of the assets and liabilities of the several funds as at that date, are included in this report.

For the year ended March 31, 1953, the accounting procedures of the Association were changed from the cash receipts and disbursements method to the accrual method. This change, which was made at our suggestion, has the effect of reporting income and expense items in the year to which they properly apply. Adjustments as at March 31, 1952, the beginning of the fiscal year, resulting from this change in accounting procedure are shown in the statement of excess of assets over liabilities included herein.

Securities, comprising the entire assets of the Benevolent and Building Funds, are held in safekeeping by the Federal Reserve Bank of Atlanta and were confirmed by direct correspondence.

Assets of the Abner Wellborn Calhoun Lectureship Fund, consisting of cash and securities, were accounted for by direct correspondence with The Citizens and Southern National Bank, Atlanta, Georgia, Trustee.

The amount stated for accounts receivable in the accompanying Statement of Assets and Liabilities is as shown by the books of The Association. We mailed statements to all debtors, requesting confirmation of the balances as of March 31, 1953, and no differences were reported in the replies received. The amount for accounts payable represents a listing of unpaid invoices on hand without further verification by us.

Deferred income, consisting of membership dues, exhibitors' fees, and subscriptions to The Journal, is applicable to the remaining months of the year ended December 31, 1953, and was computed by us.

Insurance protection of The Association at March 31, 1953, as determined from policies submitted for our inspection, is shown on another page of this report.

The Association remitted \$51,348.50 to The American Medical Association during the year representing dues collected for that association.

Certified Public Accountants
ERNST & ERNST

Atlanta, Georgia
April 13, 1953

STATEMENT OF ASSETS AND LIABILITIES — BY FUNDS

The Medical Association of Georgia

March 31, 1953

	General Fund	Benevolent and Building Fund	Abner W. Calhoun Lectureship Fund	Combined
ASSETS				
Cash	\$33,740.83	\$ —	\$ 226.63	\$ 33,967.46
Securities owned—at cost	—	63,320.00	5,535.50	68,855.50
Accounts receivable	1,933.27	—	—	1,933.27
Office furniture and equipment—Note A	3,598.75	—	—	3,598.75
Less allowance for depreciation	758.42	—	—	758.42
	<u>\$ 2,840.33</u>	<u>\$ —</u>	<u>\$ —</u>	<u>\$ 2,840.33</u>
Prepaid annual meeting expenses	1,015.00	—	—	1,015.00
TOTAL ASSETS	<u>\$39,529.43</u>	<u>\$63,320.00</u>	<u>\$ 5,762.13</u>	<u>\$108,611.56</u>
LIABILITIES				
Accounts payable	\$ 633.05	\$ —	\$ —	\$ 633.05
Withholding and pay roll taxes	883.95	—	—	883.95
Deferred income:				
Membership dues	11,328.75	—	—	11,328.75
Exhibitors' fees—1953 annual meeting	5,480.00	—	—	5,480.00
Unearned subscriptions to The Journal	5,802.56	—	—	5,802.56
	<u>\$22,611.31</u>	<u>\$ —</u>	<u>\$ —</u>	<u>\$ 22,611.31</u>
TOTAL LIABILITIES	<u>\$24,128.31</u>	<u>\$ —</u>	<u>\$ —</u>	<u>\$ 24,128.31</u>
EXCESS OF ASSETS OVER LIABILITIES	<u>\$15,401.12</u>	<u>\$63,320.00</u>	<u>\$ 5,762.13</u>	<u>\$ 84,483.25</u>

NOTE A—Office furniture and equipment is stated at cost and does not include items purchased prior to April 1, 1949.

STATEMENT OF EXCESS OF ASSETS OVER LIABILITIES — BY FUNDS

The Medical Association of Georgia

March 31, 1953

	General Fund	Benevolent and Building Fund	Abner W. Calhoun Lectureship Fund	Combined
Excess of assets over liabilities at March 31, 1952, as shown by report	\$53,733.81	\$63,320.00	\$ 5,737.94	\$122,791.75
Charges as at March 31, 1952, incident to change from cash receipts and disbursements method to accrual method of accounting:				
Prepaid dues	11,887.50	—	—	11,887.50
Prepaid subscriptions	5,943.75	—	—	5,943.75
Exhibitors fees applicable to 1952 meeting	8,975.00	—	—	8,975.00
Depreciation applicable to prior years	434.94	—	—	434.94
Pay roll taxes and other expenses applicable to prior years	205.94	—	—	205.94
Transfer from Lectureship Fund to General Fund to reimburse for lecture at 1952 convention	200.00*	—	200.00	—
Total charges as at March 31, 1952	\$27,247.13	\$ —	\$ 200.00	\$ 27,447.13
Adjusted balances—March 31, 1952	\$26,486.68	\$63,320.00	\$ 5,537.94	\$ 95,344.62
Net income or deficit* for year ended March 31, 1953, as shown by statement of income and expense	12,335.56*	1,250.00	224.19	*10,861.37
Income of Benevolent and Building Fund deposited in General Fund account	1,250.00	1,250.00*	—	—
Excess of assets over liabilities at March 31, 1953, as shown by this report	\$15,401.12	\$63,320.00	\$ 5,762.13	\$ 84,483.25

*Indicates red figures.

STATEMENT OF INCOME AND EXPENSE — BY FUNDS

The Medical Association of Georgia

Year ended March 31, 1953

	General Fund	Benevolent and Building Fund	Abner W. Calhoun Lectureship Fund	Combined
INCOME				
Membership dues	\$21,303.75	\$ —	\$ —	\$21,303.75
Net income from The Journal—as shown by schedule	2,197.45	—	—	2,197.45
Fees from exhibitors at 1952 annual meeting, less expenses of meeting of \$5,738.55	3,391.45	—	—	3,391.45
Interest on savings share account	228.78	—	—	228.78
Interest on U. S. Savings bonds	—	1,250.00	—	1,250.00
Dividends on stocks owned	—	—	235.52	235.52
	\$27,121.43	\$ 1,250.00	\$ 235.52	\$28,606.95
EXPENSES				
Salaries:				
Secretary and Treasurer	\$ 3,000.00	\$ —	\$ —	\$ 3,000.00
Executive Secretary	6,000.00	—	—	6,000.00
Managing Editor	4,050.00	—	—	4,050.00
Clerical, etc.	8,212.02	—	—	8,212.02
Less allocated to The Journal	6,601.48*	—	—	6,601.48*
	\$14,660.54	\$ —	\$ —	\$14,660.54
Trustees' fees	—	—	11.33	11.33

Administrative and other expenses—as shown by schedule	26,078.71	—	—	26,078.71
	<u>\$40,739.25</u>	<u>\$ —</u>	<u>\$ 11.33</u>	<u>\$40,750.58</u>
OTHER INCOME	\$13,617.82*	\$ 1,250.00	\$ 224.19	\$12,143.63*
Profit on equipment sold—net.....	\$ 807.48	\$ —	\$ —	\$ 807.48
Received from A.M.A. for services, postage, etc.....	474.78	—	—	474.78
	<u>\$ 1,282.26</u>	<u>\$ —</u>	<u>\$ —</u>	<u>\$ 1,282.26</u>
NET INCOME—DEFICIT*	<u>\$12,335.56*</u>	<u>\$ 1,250.00</u>	<u>\$ 224.19</u>	<u>\$10,861.37*</u>

*Indicates red figures.

NET INCOME FROM THE JOURNAL

The Medical Association of Georgia

Year ended March 31, 1953

INCOME

Advertising			\$18,612.97
Subscriptions			\$10,761.44
TOTAL INCOME			<u>\$29,374.41</u>

EXPENSES

Salaries:			
Managing Editor	\$ 4,050.00		
Other	2,551.48	\$ 6,601.48	
Publication expenses:			
Printing		\$16,708.09	
Cuts of illustrations		503.63	
Editorial assistance		477.50	
Stationery		267.77	
Portion of general administrative expenses.....		900.00	
Postage		930.42	
Clipping service		183.80	
Addressograph—mimeograph service and supplies.....		246.63	
Copyright fee		48.00	
Pay roll tax		98.98	
Sundry		210.66	27,176.96
NET INCOME			<u>\$ 2,197.45</u>

ADMINISTRATIVE AND OTHER EXPENSES

The Medical Association of Georgia

Year ended March 31, 1953

Traveling		\$ 3,496.72
Meetings		823.31
Medical defense		492.53
Insurance		45.36
Contributions:		
Education fund—American Medical Association.....	\$10,000.00	
Fulton County Medical Society.....	1,200.00	
Better Health Council of Georgia.....	1,000.00	
Woman's Auxiliary to The Association.....	936.71	13,136.71
Stationery and printing		1,930.47
Pensions		1,050.00
Legal and professional.....		1,700.00
Honorarium to president.....		315.00

Postage	379.38
Telephone and telegraph	941.71
Provision for depreciation	323.48
Public policy and legislation	246.94
Rural health	336.37
Office supplies and expenses	490.83
Dues and subscriptions	232.15
Janitor service	188.00
Pay roll tax	183.92
Mailing service	180.00
Prepayment medical care plans	245.00
Sundry	240.83
Portion of administrative expense charged to The Journal	900.00*
TOTAL	\$26,078.71

*Indicates red figures.

CASH — GENERAL FUND
The Medical Association of Georgia
March 31, 1953

ON DEPOSIT

The Citizens and Southern National Bank, Atlanta, Georgia	\$26,528.40
Standard Federal Savings and Loan Association, Atlanta, Georgia	7,212.43
TOTAL	\$33,740.83

BENEVOLENT AND BUILDING FUNDS — SECURITIES OWNED

The Medical Association of Georgia
March 31, 1953

UNITED STATES SAVINGS BONDS

	Cost	Face Amount	Redemption Value
SERIES F			
Due June 1, 1956	\$ 7,400.00	\$10,000.00	\$ 8,870.00
Due June 1, 1961	5,920.00	8,000.00	6,136.00
SERIES G			
Due July 1, 1957	15,000.00	15,000.00	14,460.00
Due Mar. 1, 1959	15,000.00	15,000.00	14,325.00
Due Jan. 1, 1960	15,000.00	15,000.00	14,235.00
Due Jan. 1, 1962	5,000.00	5,000.00	4,755.00
TOTAL	\$63,320.00	\$68,000.00	\$62,781.00

NOTE—The Association has appropriated funds for benevolence and building as follows:

Benevolence	\$25,000.00
Building	35,000.00
TOTAL	\$60,000.00

ABNER WELLBORN CALHOUN LECTURESHIP FUND

(The Citizens and Southern National Bank, Atlanta, Georgia — Trustee)

The Medical Association of Georgia
Year ended March 31, 1953

CASH HELD BY TRUSTEE

	Principal Cash	Income Cash	Combined
Balance at March 31, 1952	\$ 34.80	\$ 167.64	\$ 202.44
Receipts:			

Dividends received:			
Georgia Power Company—\$6.00 preferred stock.....	—	150.00	150.00
Atlanta Gas Light Company—4½ % preferred stock.....	—	85.52	85.52
Transferred to "Principal" from "Income"—Note A.....	15.19	15.19*	—
	<u>\$ 49.99</u>	<u>\$ 387.97</u>	<u>\$ 437.96</u>
Disbursements:			
Paid to The Medical Association of Georgia to reimburse General Fund for payment to Dr. D. A. Wright for lecture at 1952 annual meeting	\$ —	\$ 200.00	\$ 200.00
Trustees' fee	—	11.33	11.33
	<u>\$ —</u>	<u>\$ 211.33</u>	<u>\$ 211.33</u>
BALANCE AT MARCH 31, 1953.....	<u>\$ 49.99</u>	<u>\$ 176.64</u>	<u>\$ 226.63</u>

SECURITIES HELD BY TRUSTEE

	Number of Shares	Market Value	Carrying Amount
Atlanta Gas Light Company—4½ % preferred stock.....	19	\$1,938.00	\$1,971.50
Georgia Power Company—\$6.00 preferred stock.....	25	2,900.00	2,849.00
Southwestern Railroad—common stock	13	780.00	715.00
		<u>\$5,618.00</u>	<u>\$5,535.50</u>
TOTAL CASH AND SECURITIES AT MAR. 31, 1953....			<u>\$5,762.13</u>

NOTE A—Under the provisions of the trust indenture "all unexpended income in the hands of the Trustees on July 1st of each year shall be added to the principal of the trust fund".

*Indicates red figures.

ACCOUNTS RECEIVABLE

The Medical Association of Georgia

March 31, 1953

EXHIBITORS AT 1953 ANNUAL MEETING

Baker Laboratory, Inc.....	\$170.00	
Chicago Pharmacal Company	100.00	
General Electric Company	140.00	
Marks Surgical Supplies, Inc.....	100.00	
Table Rock Laboratories, Inc.....	170.00	
Tattle Toe	110.00	\$ 790.00

FOR ADVERTISING IN THE JOURNAL

Walter W. Ballard Optical Company.....	\$ 15.00	
Blackman's Sanitarium	17.50	
William M. Cason, M.D.....	4.00	
City View Sanitarium	12.00-A	
The Coca-Cola Company	29.32-A	
Eager and Simpson	6.90-A	
A. B. Ellerbee	22.45	
Georgia Baptist Hospital.....	12.00	
Lane-Rexall Drug Stores	17.59-A	
R. L. Mathis	10.00	
Peachtree Sanitarium	57.48-A	
State Advertising Bureau	905.79-A	
St. Joseph's Infirmary	16.00-A	
J. Walter Thompson Company.....	17.24-A	1,143.27
TOTAL		<u>\$1,933.27</u>

Items marked "A" were collected after March 31, 1953, and before April 12, 1953.

ACCOUNTS PAYABLE
The Medical Association of Georgia
March 31, 1953

Advertisers' credit balances	\$140.00
American Medical Association	24.00
Dunaway, Howard, and Embry	25.00
Charles R. Hadley Company97
Fulton County Medical Society	300.00
Spencer A. Kirkland, M.D.	93.08
Jack Norris, M.D.	50.00
TOTAL	\$633.05

INSURANCE PROTECTION
The Medical Association of Georgia
March 31, 1953

FIRE AND EXTENDED COVERAGE	
Contents of building	\$ 4,000.00-A
LOSS OR DAMAGE TO PROJECTORS, LOUDSPEAKERS,	
SCREENS, PUBLIC ADDRESS SYSTEM, ETC.	2,520.00
AUTOMOBILE—(Employees' cars)	
Bodily injury	100/300,000.00
Property damage	5,000.00
FIDELITY BONDS	
David Henry Poer	\$10,000.00
Sidney Ray Wrightsman, Jr.	1,000.00
Thelma Viola Franklin	1,000.00 \$12,000.00

NOTE A—Loss payable to Dr. David Henry Poer, Secretary and Treasurer, The Medical Association of Georgia.

REPORT OF EXAMINATION AND SUPPLEMENTARY DATA

THE MEDICAL ASSOCIATION OF GEORGIA — ATLANTA, GEORGIA

DECEMBER 31, 1953

ERNST & ERNST

Accountants and Auditors, Atlanta

Dr. H. L. Cheves
Chairman of The Council
The Medical Association of Georgia
Union Point, Georgia

We have examined the books of The Medical Association of Georgia for the period of nine months ended December 31, 1953, as maintained in the office of its Secretary and Treasurer. The scope of our examination included a test of the records of cash transactions for the period under review by comparisons of the totals of recorded cash receipts with deposits shown by monthly bank statements on file, and by inspection of paid checks, invoices, or other data on file in support of the recorded disbursements. Cash on deposit and for deposit was reconciled with the amounts reported to us by the depositories. We also accounted for the income of the Benevolent and Building Funds and the Abner Wellborn Calhoun Lectureship Fund for the period of nine months ended December 31, 1953, and the assets held in those funds at that date.

Statements of income and expense, by funds, for the period of nine months ended December 31, 1953, and a statement of assets and liabilities of the several funds as at that date, are included herein.

Securities, comprising the entire assets of the Benevolent and Building Funds, are held in safekeeping by the Federal Reserve Bank of Atlanta and were confirmed by direct correspondence.

Assets of the Abner Wellborn Calhoun Lectureship Fund, consisting of cash and securities, were accounted for by direct communication with The Citizens and Southern National Bank, Atlanta, Georgia—Trustee.

The amount stated for accounts receivable in the accompanying statement of assets and liabilities is as shown by the books of the Association. We mailed statements to all debtors requesting confirmation of the balances at December 31, 1953, and no differences were reported in the replies received. The amount shown for accounts payable represents a listing of unpaid items on hand without further verification by us.

We examined policies evidencing the insurance protection of the Association at December 31, 1953, a summary of which is included herein.

Dues collected for and remitted to the American Medical Association during the nine months ended December 31, 1953, aggregated \$13,850.00.

ERNST & ERNST

Certified Public Accountants

Atlanta, Georgia
March 10, 1954

STATEMENT OF ASSETS AND LIABILITIES — BY FUNDS

The Medical Association of Georgia

December 31, 1953

	General Fund	Benevolent and Building Fund	Abner W. Calhoun Lectureship Fund	Combined
ASSETS				
Cash on deposit and for deposit	\$ 8,732.61	\$ —	\$ 186.14	\$ 8,918.75
Securities owned—at cost	—	63,320.00	5,800.85	69,120.85
Accounts receivable	4,095.20	—	—	4,095.20
Office furniture and equipment—Note	3,722.55	—	—	3,722.55
Less Allowance for depreciation	1,032.93	—	—	1,032.93
	<u>\$ 2,689.62</u>	<u>\$ —</u>	<u>\$ —</u>	<u>\$ 2,689.62</u>
Prepaid annual meeting expense	303.08	—	—	303.08
	<u>\$ 15,820.51</u>	<u>\$ 63,320.00</u>	<u>\$ 5,986.99</u>	<u>\$ 85,127.50</u>
TOTAL ASSETS				
LIABILITIES				
Accounts payable	\$ 131.75	\$ —	\$ —	\$ 131.75
Withholding and pay roll taxes	668.85	—	—	668.85
Deferred income:				
Exhibitors' fees—1954 annual meeting	6,150.00	—	—	6,150.00
	<u>\$ 6,950.60</u>	<u>\$ —</u>	<u>\$ —</u>	<u>\$ 6,950.60</u>
TOTAL LIABILITIES				
EXCESS OF ASSETS OVER LIABILITIES	<u>\$ 8,869.91</u>	<u>\$ 63,320.00</u>	<u>\$ 5,986.99</u>	<u>\$ 78,176.90</u>

NOTE—Office furniture and equipment is stated at cost and does not include items purchased prior to April 1, 1949.

STATEMENT OF EXCESS OF ASSETS OVER LIABILITIES — BY FUNDS

The Medical Association of Georgia

Period of nine months ended December 31, 1953

	General Fund	Benevolent and Building Fund	Abner W. Calhoun Lectureship Fund	Combined
Excess of assets over liabilities at March 31, 1953, as shown by report	\$15,401.12	\$63,320.00	\$ 5,762.13	\$84,483.25
Net income—deficit* for period of nine months ended				

December 31, 1953, as shown by statement of income and expense	6,531.21*	—	224.86	6,306.35*
EXCESS OF ASSETS OVER LIABILITIES—				
DECEMBER 31, 1953	\$ 8,869.91	\$63,320.00	\$ 5,986.99	\$78,176.90

STATEMENT OF INCOME AND EXPENSE — BY FUNDS

The Medical Association of Georgia

Period of nine months ended December 31, 1953

	General Fund	Abner W. Calhoun Lecture Fund	Combined
INCOME			
Membership dues	\$17,395.50	\$ —	\$17,395.50
Net income from The Journal—as shown by schedule	1,445.50	—	1,445.50
Interest on savings share account	236.28	—	236.28
Interest on U. S. Savings bonds—Note	625.00	—	625.00
Dividends on stocks owned	—	176.64	176.64
TOTAL INCOME	\$19,702.28	\$ 176.64	\$19,878.92
EXPENSES			
Salaries:			
Secretary and treasurer	\$ 2,250.00	\$ —	\$ 2,250.00
Executive secretary	4,533.33	—	4,533.33
Managing editor—The Journal	3,900.00	—	3,900.00
Clerical, etc.	6,181.25	—	6,181.25
Less allocated to The Journal, etc.	6,350.00*	—	6,350.00*
	\$10,514.58	\$ —	\$10,514.58
Lecture at annual meeting	—	200.00	200.00
Trustees' fee	—	11.78	11.78
Expenses of annual meeting, less fees from exhibitors of \$5,335.00	3,020.19	—	3,020.19
Administrative and other expenses—as shown by schedule	13,648.22	—	13,648.22
TOTAL EXPENSES	\$27,182.99	\$ 211.78	\$27,394.77
NET EXPENSES	\$ 7,480.71	\$ 35.14	\$ 7,515.85
OTHER INCOME			
Profit on stock sold	\$ —	\$ 260.00	\$ 260.00
Received from A.M.A. for services, postage, etc.	449.50	—	449.50
Profit on equipment sold	500.00	—	500.00
TOTAL OTHER INCOME	\$ 949.50	\$ 260.00	\$ 1,209.50
NET INCOME—DEFICIT*	\$ 6,531.21*	\$ 224.86	\$ 6,306.35*

*Indicates red figures.

NOTE—On May 10, 1953, The Council authorized interest received on U. S. Savings bonds held in the Benevolent and Building Funds to be recorded in the General Fund.

NET INCOME FROM THE JOURNAL

The Medical Association of Georgia

Period of nine months ended December 31, 1953

INCOME		
Advertising		\$12,699.99
Subscriptions		9,131.66
TOTAL INCOME		\$21,831.65
EXPENSES		
Salaries:		
Managing Editor	\$3,900.00	
Other	1,625.00	\$ 5,525.00

Publication expenses:			
Printing	\$12,167.29		
Cuts of illustrations	490.12		
Editorial assistance	169.50		
Stationery	721.29		
Portion of general administrative expense.....	675.00		
Postage	328.42		
Clipping service	145.65		
Addressograph-mimeograph service and supplies	94.53		
Pay roll tax	69.35	14,861.15	20,386.15
NET INCOME			<u>\$1,445.50</u>

ADMINISTRATIVE AND OTHER EXPENSES

The Medical Association of Georgia

Period of nine months ended December 31, 1953

Traveling		\$ 2,359.62	
Meetings		356.13	
Medical defense		545.80	
Contributions:			
Fulton County Medical Society	\$ 900.00		
Better Health Council of Georgia.....	1,000.00		
Crawford W. Long Memorial Museum.....	1,000.00		
Woman's Auxiliary to The Association.....	850.00	3,750.00	
Stationery and printing		576.27	
Pensions		1,350.00	
Legal and professional		1,125.00	
Honorarium to president		1,000.00	
Postage		310.59	
Telephone and telegraph		964.29	
Provision for depreciation		274.51	
Public policy and legislation		62.61	
Veterans' affairs		114.80	
Office supplies and expense.....		77.13	
Dues and subscriptions		260.00	
Janitor service and extra labor.....		195.00	
Pay roll tax		133.58	
Maternal welfare		90.90	
Prepayment medical care plans		269.37	
Public relations (less \$590.00 contributed by members).....		8.82	
Sundry		498.80	
Portion of administrative expense charged to The Journal.....		675.00*	
TOTAL		<u>\$13,648.22</u>	

*Indicates red figures.

CASH — GENERAL FUND

The Medical Association of Georgia

December 31, 1953

ON DEPOSIT AND FOR DEPOSIT

The Citizens and Southern National Bank, Atlanta, Georgia—		
(includes cash for deposit of \$1,409.45)	\$1,283.90	
Standard Federal Savings and Loan Association, Atlanta, Georgia.....	7,448.71	
TOTAL	<u>\$8,732.61</u>	

BENEVOLENT AND BUILDING FUNDS — SECURITIES OWNED

The Medical Association of Georgia

December 31, 1953

U. S. SAVINGS BONDS

SERIES F

	Cost	Face Amount	Redemption Value
Due June 1, 1956.....	\$ 7,400.00	\$10,000.00	\$ 9,140.00
Due June 1, 1961.....	5,920.00	8,000.00	6,288.00

SERIES G

Due July 1, 1957.....	15,000.00	15,000.00	14,505.00
Due Mar. 1, 1959.....	15,000.00	15,000.00	14,370.00
Due Jan. 1, 1960.....	15,000.00	15,000.00	14,205.00
Due Jan. 1, 1962.....	5,000.00	5,000.00	4,740.00

TOTAL	<u>\$63,320.00</u>	<u>\$68,000.00</u>	<u>\$63,248.00</u>
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NOTE—The Association has appropriated funds for benevolence and building as follows:

Benevolence	\$25,000.00
Building	35,000.00
TOTAL	<u>\$60,000.00</u>

ABNER WELLBORN CALHOUN LECTURESHIP FUND

(The Citizens and Southern National Bank, Atlanta, Georgia — Trustee)

The Medical Association of Georgia

Period of nine months ended December 31, 1953

CASH HELD BY TRUSTEE

	Principal Cash	Income Cash	Combined
Balance at March 31, 1953.....	\$ 49.99	\$ 176.64	\$ 226.63
Receipts:			
Dividends received:			
Georgia Power Company—\$6.00 preferred stock.....	—	112.50	112.50
Atlanta Gas Light Company—4½ % preferred stock.....	—	64.14	64.14
Proceeds from sale of 13 shares Southwestern Railroad common stock	975.00	—	975.00
Transfer—Note	23.74	23.74*	—
	<u>\$1,048.73</u>	<u>\$ 329.54</u>	<u>\$1,378.27</u>

Disbursements:

Purchase of 10 shares American Bakeries of Delaware 4½ % preferred stock	\$ 980.35	\$ —	\$ 980.35
Dr. Cyrus C. Sturgis—for lecture at 1953 annual meeting.....	—	200.00	200.00
Trustees' fee	—	11.78	11.78
	<u>\$ 980.35</u>	<u>\$ 211.78</u>	<u>\$1,192.13</u>

BALANCE AT DECEMBER 31, 1953.....	<u>\$ 68.38</u>	<u>\$ 117.76</u>	<u>\$ 186.14</u>
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SECURITIES HELD BY TRUSTEE

	Number of Shares	Market Value	Carrying Amount
American Bakeries Company—4½ % preferred stock.....	10	\$ 987.50	\$ 980.35
Atlanta Gas Light Company—4½ % preferred stock.....	19	1,871.50	1,971.50
Georgia Power Company—\$6.00 preferred stock.....	25	2,893.75	2,849.00
		<u>\$5,752.75</u>	<u>\$5,800.85</u>

TOTAL CASH AND SECURITIES AT DEC. 31, 1953.....			<u>\$5,986.99</u>
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NOTE—Under provisions of the trust indenture "all unexpended income in the hands of the Trustee on July 1st of each year shall be added to the principal of the trust fund".

*Indicates red figures.

ACCOUNTS RECEIVABLE

The Medical Association of Georgia

December 31, 1953

EXHIBITORS AT 1954 ANNUAL MEETING

Abbott Laboratories	\$150.00	
A. S. Aloe Company	300.00	
American Surgical Supply Company	150.00	
Ames Company	150.00	
Ayerst McKenna and Harrison, Ltd.	75.00	
Brayten Pharmaceutical Company	150.00	
Brown and Williamson Tobacco Company ..	150.00	
Estes Surgical Supply Company	150.00	
General Electric Company	150.00	
Hart Drug Company	150.00	
Kremers-Urban Company	150.00	
Lederle Laboratories	150.00	
M. and R. Laboratories	75.00	
S. E. Massengill Company	150.00	
William R. Poythress Company	150.00	
The Stuart Company	150.00	
Surgical Selling Company	150.00	
U. S. Vitamin Company	150.00	
Van Pelt and Brown, Inc.	150.00	
Wachtel's Physician Supply Company	150.00	\$3,000.00

FOR ADVERTISING IN THE JOURNAL

R. L. Carter, M.D.	\$ 2.00	
City Hospital—Brunswick	2.00	
Eager and Simpson	10.35	
Georgia Baptist Hospital	10.35	
E. Harris Pierce, M.D.	4.00	
Drs. Landham and Klugh	15.00	
Moyers Travel Bureau	25.90	
The New York Polyclinic Medical School and Hospital ..	.36	
Piedmont Hospital	22.35	
Ponce de Leon Infirmary	10.35	
Southern Medical Association	29.35	
State Journal Advertising Bureau	963.19	1,095.20
TOTAL		<u>\$4,095.20</u>

INSURANCE

The Medical Association of Georgia

December 31, 1953

FIRE AND EXTENDED COVERAGE

Contents of building	\$ 4,000.00-A
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AUTOMOBILE—(non-owned cars)

Bodily injury	100 / 300,000.00
Property damage	5,000.00

FIDELITY BONDS

David Henry Poer	\$10,000.00	
Sidney Ray Wrightsman, Jr.—Note B	1,000.00	
Thelma Viola Franklin	1,000.00	12,000.00

NOTE A—Loss payable to Dr. David Henry Poer, Secretary and Treasurer, The Medical Association of Georgia.

NOTE B—The former Executive Secretary (Sidney Ray Wrightsman, Jr.) resigned as of November 1, 1953, however, as of the date of this report, the fidelity bond had not been extended to cover his successor.

MAG Officers and Committees

OFFICERS FOR 1954-1955

President—Peter B. Wright, Augusta
President-Elect—H. Dawson Allen, Milledgeville
First Vice President—Willard R. Golsan, Macon
Second Vice President—Milford B. Hatcher, Macon
Secretary Treasurer—David Henry Poer, Atlanta

Delegates to the A.M.A.

Terms Expire December 31, 1955

C. H. Richardson, Sr., Macon
C. L. Ayers, Toccoa, Alternate

Terms Expire December 31, 1956

Eustace A. Allen, Atlanta
William R. Dancy, Savannah, Alternate
Spencer Kirkland, Atlanta
Henry Tift, Macon, Alternate

Councilors

District	Term Expires
1—Lee Howard, Savannah.....	1955 Session
2—George R. Dillinger, Thomasville.....	1955 Session
3—W. G. Elliott, Cuthbert.....	1955 Session
4—J. W. Chambers, LaGrange.....	1955 Session
5—Mark S. Dougherty, Jr., Atlanta.....	1956 Session
6—H. Dawson Allen, Jr., Milledgeville.....	1956 Session
7—D. Lloyd Wood, Dalton.....	1956 Session
8—Neal F. Yeomans, Waycross.....	1956 Session
9—W. Bruce Schaefer, Toccoa.....	1957 Session
10—H. L. Cheves, Union Point.....	1957 Session

Vice Councilors

District	Term Expires
1—Charles T. Brown, Guyton.....	1955 Session
2—Carl S. Pittman, Sr., Tifton.....	1955 Session
3—Guy J. Dillard, Columbus.....	1955 Session
4—Clarence B. Palmer, Covington.....	1955 Session
5—J. G. McDaniel, Atlanta.....	1956 Session
6—H. G. Weaver, Macon.....	1956 Session
7—Ralph W. Fowler, Marietta.....	1956 Session
8—James M. Hicks, Brunswick.....	1956 Session
9—Charles R. Andrews, Jr., Canton.....	1957 Session
10—J. Victor Roule, Augusta.....	1957 Session

Executive Committee

Peter B. Wright, President, Augusta—1955
William Harbin, Past President, Rome—1956
H. Dawson Allen, President-Elect, Milledgeville—1958
David Henry Poer, Secretary-Treasurer, Atlanta—1957
H. L. Cheves, Chairman of Council, Union Point—1955
J. W. Chambers, Member of Council, LaGrange—1955

Committee on Auditing and Appropriations

Terms Expire 1955 Session

J. W. Chambers, Chairman, LaGrange
D. Lloyd Wood, Dalton
Mark S. Dougherty, Jr., Atlanta

Honorary Advisory Board

W. S. Goldsmith.....	President, 1915-1916
J. W. Palmer.....	President, 1918-1919
C. K. Sharp.....	President, 1928-1929
William R. Dancy.....	President, 1929-1930
M. M. Head.....	President, 1932-1933
C. H. Richardson.....	President, 1933-1934
Clarence L. Ayers.....	President, 1934-1935
B. H. Minchew.....	President, 1936-1937
Grady N. Coker.....	President, 1938-1939
J. C. Patterson.....	President, 1940-1941
Allen H. Bunce.....	President, 1941-1942
James A. Redfearn.....	President, 1942-1943
W. A. Selman.....	President, 1943-1944
Cleveland Thompson.....	President, 1944-1946
Ralph H. Chaney.....	President, 1946-1947
Enoch Callaway.....	President, 1949-1950
A. M. Phillips.....	President, 1950-1951
W. F. Reavis.....	President, 1951-1952
C. F. Holton.....	President, 1952-1953
William Harbin.....	President, 1953-1954

MAG STANDING COMMITTEES, 1954-55

(One member appointed annually to serve for 3 years—terms expire at Annual Session)

Scientific Work

Charles H. Prince, Chairman, Savannah—1955
Fred H. Simonton, Chickamauga—1956
Thomas W. Goodwin, Augusta—1957
David Henry Poer, Atlanta—1957
Peter B. Wright, Augusta—1955

Legislation

Grady N. Coker, Chairman, Canton—1957
Carl C. Aven, Atlanta—1955
Joseph D. McElroy, Atlanta—1956
Mr. Roy V. Harris, Legal Advisor, Augusta—1955

Medical Education

R. Hugh Wood, Chairman, Emory University—1955
E. R. Pund, Augusta—1956
Julian Quattlebaum, Savannah—1957

Medical Defense

Marion C. Pruitt, Chairman, Atlanta—1958
David Henry Poer, Atlanta—1957
Perry Volpito, Augusta—1956
John McPherson, Jr., Athens—1957
H. L. Cheves, Union Point—1955

Professional Conduct

Enoch Callaway, Chairman, LaGrange—1955
A. M. Phillips, Macon—1956
W. F. Reavis, Waycross—1956
C. F. Holton, Savannah—1958
William Harbin, Rome—1959

History and Vital Statistics

J. Calvin Weaver, Chairman, Atlanta—1955
H. L. Erwin, Dalton—1956
Hoke Wammock, Augusta—1957
Edgar Woody, Jr., Atlanta, Ex-officio
Grady N. Coker, Canton, Ex-officio

Public Health

T. A. Sappington, Chairman, Thomaston—1956
B. H. Hand, LaGrange—1957
R. F. Spanjer, Cedartown—1955
T. F. Sellers, ex-officio, Atlanta
Rufus Payne, Augusta—1955

Maternal and Infant Welfare

Peter Hydrick, Chairman, College Park—1956
Tom McPherson, Atlanta—1957
C. M. Mulherin, Augusta—1955
Helen W. Bellhouse, Atlanta—1955
Hugh Bickerstaff, Columbus—1957
Eugene Griffin, Atlanta—1957
Howard J. Morrison, Savannah—1956
F. H. Simonton, Chickamauga—1955
George Alexander, Forsyth—1956

Woman's Auxiliary

Enoch Callaway, Chairman, LaGrange—1955
Shelley C. Davis, Atlanta—1955
Willard R. Golsan, Macon—1957
W. G. Elliott, Cuthbert—1956
W. Bruce Schaefer, Toccoa—1956

Awards

Hoke Wammock, Chairman, Augusta—1955
Mark S. Dougherty, Jr., Atlanta—1957
W. E. Storey, Columbus—1956

Constitution and By-Laws

J. W. Chambers, Chairman, LaGrange—1957
T. W. Goodwin, Augusta—1955
H. G. Weaver, Macon—1955
David Henry Poer, Atlanta—1957
William Harbin, Rome—1956

Industrial Health

Duncan Shepard, Chairman, Atlanta—1956
John G. Sharpley, Savannah—1955
Robert M. Harbin, Jr., Rome—1956
Charles L. Ridley, Jr., Macon—1957
George R. Conner, Columbus—1956
W. Bruce Schaefer, Toccoa—1955
Allen Collinsworth, Atlanta—1957
Alfred M. Battey, Augusta—1955

Subcommittee on Compensation Insurance

Allen Collinsworth, Atlanta—1955
Joseph C. Read, Atlanta—1955
Joseph Kurtz, Atlanta—1955
Duncan Shepard, Atlanta—1955

Public Relations

Chris J. McLoughlin, Chairman, Atlanta—1956
Peter L. Scardino, Savannah—1957
Thomas L. Ross, Jr., Macon—1955
J. Lamont Henry, Atlanta—1957
J. L. Chandler, Jr., Augusta—1957
Eugene Ward, Gainesville—1955
Warren M. Gilbert, Rome—1955

W. C. Cook, Columbus—1956
Geo. R. Dillinger, Thomasville—1957

Cancer

J. E. Scarborough, Chairman, Atlanta*—1955
Hoke Wammock, Augusta*—1956
David Henry Poer, Atlanta*—1957
R. C. Pendergrass, Americus*—1957
Enoch Callaway, LaGrange*—1956
W. F. Jenkins, Columbus—1955
John Funke, Atlanta—1955
John L. Barner, Athens—1956
F. D. Eldridge, Valdosta—1957
Lester Harbin, Rome—1956
Everett L. Bishop, Atlanta*—1956
Thomas Harold, Macon*—1957
Lee Howard, Savannah—1955
Neal F. Yeomans, Waycross—1956
Kirk Shepard, Thomasville—1957
Major F. Fowler, Atlanta—1955
Wadley R. Glenn, Atlanta—1956
John T. Mauldin, Atlanta—1957
* Executive Committee

Rural Health

W. W. Turner, Chairman, Nashville—1955
George T. Nicholson, Co-Chairman, Cornelia—1957
T. F. Sellers, Ex-officio, Atlanta

Districts

1—Charles T. Brown, Guyton—1957
2—H. B. Jenkins, Donalsonville—1956
4—Clarence B. Palmer, Covington—1957
5—Sterling H. Jernigan, Atlanta—1956
6—E. B. Claxton, Dublin—1955
7—B. H. Steele, Fairmount—1956
8—W. W. Turner, Nashville—1955
9—Joe R. Arrendale, Cornelia—1955
10—Lynn M. Huie, Monroe—1955

Insurance Board

David R. Thomas, Jr., Chairman, Augusta—1957
George Nicholson, Cornelia—1956
W. L. Pomeroy, Waycross—1956
Chas. S. Jones, Atlanta—1957
D. L. Wood, Dalton—1957
J. Z. McDaniel, Albany—1955
Harry Pinson, Augusta—1956
Luther Wolff, Columbus—1955
John Elliott, Savannah—1955

Veterans' Affairs

Hartwell Joiner, Chairman, Gainesville—1956
A. R. Bush, Dublin—1957
A. O. Colquitt, Jr., Marietta—1956
Bernard P. Wolff, Atlanta—1955
Charles R. Andrews, Canton—1956
Herbert Alden, Atlanta—1955
C. C. Butler, Columbus—1955
L. M. Freedman, Savannah—1956
Winston Burdine, Atlanta—1957

Hospitals

James A. Elkins, Columbus—1955
A. J. Davis, Augusta—1956
H. A. Goodwin, Summerville—1957
W. D. Hazlehurst, Macon—1957
H. Ansley Seaman, Waycross—1956
Rafe Banks, Gainesville—1955
R. C. Williams, Ex-officio, Atlanta
E. M. Lancaster, Shady Dale—1955
J. C. Patterson, Cuthbert—1955
Ernest Thompson, Monroe—1956
H. E. Weems, Perry—1956
L. C. Yeargin, Dalton—1956
W. B. Fackler, Jr., LaGrange—1957
R. F. Spanjer, Cedartown—1957
H. D. Tyler, Thomaston—1957

SPECIAL COMMITTEES

(Appointed annually)

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C. A. Eberhart, Atlanta Perry P. Volpitto, Augusta
T. J. Ferrell, Waycross J. S. Skobba, Atlanta
Lee H. Battle, Jr., Rome Charles Dowman, Atlanta

American Medical Education Foundation

John L. Chandler, Chairman, Augusta
Robt. R. McKnight, Augusta C. H. Richardson, Jr., Macon
James S. Holder, LaGrange Sage Harper, Douglas
Ernest F. Wahl, Thomasville J. Hubert Milford, Hartwell

Blood Banks

J. C. Thoroughman, Chairman, Atlanta
Lee Howard, Jr., Savannah E. Val Hastings, Augusta
Warren B. Matthews, Atlanta F. H. Thompson, Atlanta
Walter Sheppard, Augusta

Abner Wellborn Calhoun Lectureship

Glenville Giddings, Chairman, Atlanta
Charles L. Prince Savannah Edward L. Bosworth, Rome
Henry H. Tift, Macon

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L. Minor Blackford, Chairman, Atlanta
E. F. Wahl, Thomasville Harry T. Harper, Jr., Augusta
W. L. Pomeroy, Waycross J. B. Neighbors, Jr., Athens
Simone Brocato, Columbus

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Ruth M. Waring, Savannah James W. Bennett, Augusta
James Funk, Jr., Atlanta Harold Muecke, Waycross

Medical Advisory to Selective Service System

Cyrus W. Strickler, Jr., Chairman, Atlanta
W. G. Hamm, Co-Chairman, Atlanta
David Henry Poer, Atlanta A. O. Linch, Atlanta
Carter Smith, Atlanta S. A. Garrett, D.D.S., Atlanta
T. F. Sellers, Atlanta Charles C. Rife, D.V.M.,
L. Minor Blackford, Atlanta Atlanta

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Carrollton

FLORIDA: J. W. Chambers, LaGrange, and R. M. Joiner,
Moultrie

SOUTH CAROLINA: Howard J. Morrison, Savannah, and
R. C. McGahee, Augusta

TENNESSEE: William R. Dancy, Savannah, and R. N.
Little, Summerville

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First District: James M. Byne, Jr., Waynesboro, Sept. 1,
1957; Second District: A. G. Funderburk, Moultrie, Sept. 1,
1957; Third District: R. C. Montgomery, Butler, Sept. 1,
1954; Fourth District: M. M. Head, Zebulon, Sept. 1, 1955;
Fifth District: Spencer A. Kirkland, Atlanta, Sept. 1, 1954;
Sixth District: A. M. Phillips, Macon, Sept. 1, 1956; Seventh
District: Fred H. Simonton, Chickamauga, Sept. 1, 1956;
Eighth District: C. J. Malloy, McRae, Sept. 1, 1956; Ninth
District: R. Lee Rogers, Chairman, Gainesville, Sept. 1, 1956;
Tenth District: Thos. W. Goodwin, Augusta, Sept. 1, 1955;
Georgia Dental Association—J. M. Hawley, Columbus, Sept.
1, 1958, J. G. Williams, Atlanta, Sept. 1, 1958; *Georgia Phar-
maceutical Association*—J. B. Butts, Milledgeville, Sept. 1,
1959; W. W. Webb, Leslie, Sept. 1, 1959.

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Donald, Newnan; A. M. Deal, Statesboro; Alexander B. Rus-
sell, Winder; Rufus A. Askew, Atlanta; W. H. Powell, Hazle-
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J. Hubert Milford, Vice-Chairman, Hartwell
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William Harbin, Rome

Meeting of Executive Committee of Council

May 2, 1954 Macon, Georgia

The final meeting of the Council Executive Committee of the Medical Association of Georgia, 1953-54, was called to order by President William Harbin at 9:30 a.m. in the A and B Room of the Dempsey Hotel, Macon, May 2, 1954.

Members present were William Harbin, Rome; David Henry Poer, Atlanta; H. L. Cheves, Union Point; George Dillinger, Thomasville, and Mark S. Dougherty, Jr., Atlanta. Also present was Mr.

Milton D. Krueger, Executive Secretary.

The eligibility of life members nominated by the component county medical societies to be elected by the House of Delegates at the 104th Annual Session of the MAG was discussed.

The following motion was made and duly seconded. It reads as follows:

1. Those physicians recommended by their county societies for life membership to the House of Delegates at this 1954 Annual Session shall

Amebiasis¹ a "Poorly Reported" Disease

*Until serious complications arise,
amebiasis may pass unrecognized and
patients receive only symptomatic treatment.*

Although amebiasis is a disease with serious morbidity and mortality, statistics on its incidence¹ are incomplete because its manifestations are not commonly recognized and consequently not reported.

"Vague symptoms² referable to the gastrointestinal tract, such as indigestion or indefinite abdominal pains, with or without abnormally formed stools, may result from intestinal amebiasis. Not infrequently in cases in which such symptoms are ascribed to psychoneurosis after extensive x-ray studies have been carried out, complete relief is obtained with antiamebic therapy."

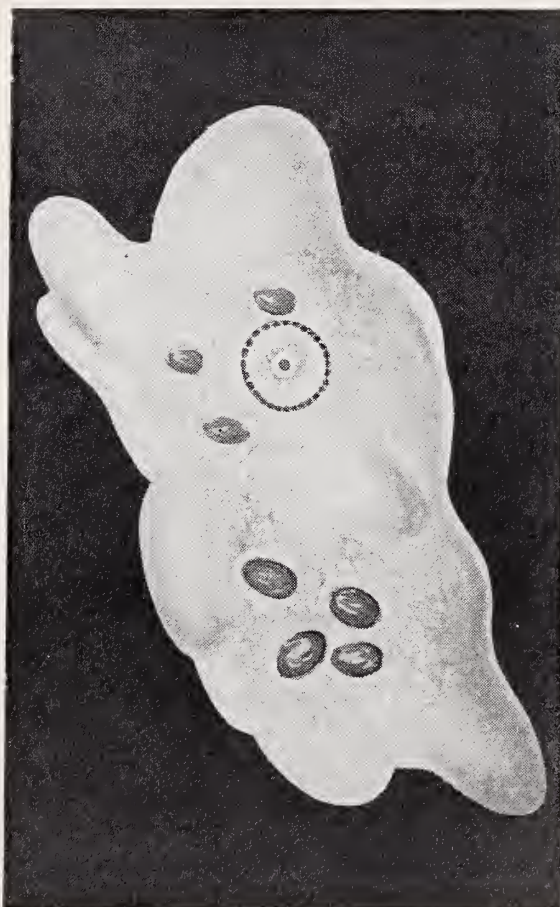
To prevent possible development of an incapacitating or even fatal illness and to eliminate a reservoir of infection in the community, diagnosing and treating³ even seemingly healthy "carriers" and those having mild symptoms of amebiasis is advised.

Early diagnosis¹ is important because infection can be rapidly and completely cleared, with the proper choice of drugs and due consideration for the principles of therapy. For treatment of the bowel phase these authors find Diodoquin "most satisfactory."

For chronic amebic infections, Goodwin⁴ finds Diodoquin to be one of the best drugs at present available.

Diodoquin, which does not inconvenience the patient or interfere with his normal activities, may be used in the treatment of acute or latent forms of amebiasis. If extraintestinal lesions require the use of emetine, Diodoquin may be administered concurrently. It is a well tolerated and relatively nontoxic orally administered amebicide, containing 63.9 per cent of iodine.

Diodoquin (diiodohydroxyquinoline), available in 10-grain (650 mg.) tablets, reduces the course of treatment to twenty days (three tablets daily). Treatment may be repeated or prolonged without



Endamoeba histolytica (trophozoite).

serious toxic effect. It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. G. D. Searle & Co., Research in the Service of Medicine.

1. Hamilton, H. E., and Zavala, D. C.: Amebiasis in Iowa: Diagnosis and Treatment, J. Iowa M. Soc. 42:1 (Jan.) 1952.

2. Goldman, M. J.: Less Commonly Recognized Clinical Features of Amebiasis, California Med. 76:266 (April) 1952.

3. Weingarten, M., and Herzig, W. F.: The Clinical Manifestations of Chronic Amebiasis, Rev. Gastroenterol. 20:667 (Sept.) 1953.

4. Goodwin, L. G.: Review Article: The Chemotherapy of Tropical Disease: Part I. Protozoal Infections, J. Pharm. & Pharmacol. 4:153 (March) 1952.

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have full privileges of membership, attend all sessions and have voting privileges.

2. That these same physicians be recommended to the House of Delegates for life membership at the 1954 Annual Session.

3. That all county society secretaries be notified that any member recommended for life membership to the House of Delegates in the future

must be in good standing, having paid his dues by January 1 and not in arrears as of April 1.

The motion carried and was to be submitted as a recommendation to the Council of the Medical Association of Georgia.

There being no further business, President Harbin called for a motion to adjourn and it was so voted.

MAG Council Meeting

May 2, 1954 Macon, Georgia

The final meeting of the 1953-54 Council of the Medical Association of Georgia was called to order by Council Chairman Cheves at 10:35 a.m. in the A & B Room of the Dempsey Hotel, Macon, Georgia, May 2, 1954.

Invocation and roll call were given by Secretary Poer.

Present at this meeting were: Mark Dougherty, Atlanta; Harry L. Cheves, Union Point; William Harbin, Rome; Neal F. Yeomans, Waycross; D. Lloyd Wood, Dalton; Milford B. Hatcher, Macon; Lee Howard, Savannah; Peter B. Wright, Augusta; James C. Metts, Savannah; J. W. Chambers, LaGrange; Ralph W. Fowler, Marietta; C. B. Palmer, Covington; David Henry Poer, Atlanta; Charles Andrews, Canton; W. G. Elliott, Cuthbert; J. G. McDaniel, Atlanta; Grady N. Coker, Canton; Willard R. Golsan, Macon; W. Bruce Schaefer, Toccoa; Edgar Woody, Atlanta and Messrs. Milton Krueger and John Kiser, Atlanta.

The minutes of the meeting of Council held January 17, 1954, in Rome, Georgia, and the Executive Committee meeting of Council, February 23, 1954, Atlanta, were read by Mr. Krueger. It was voted and duly seconded that these minutes be adopted.

Councilor Chambers reported for the Audit and Appropriations Committee and added for the information of Council that during the year 1953 the Association operated within the cash balance as of that year.

President-Elect Peter B. Wright asked that the Committee on Audit and Appropriations consider an increased appropriation for the Public Relations Committee and Councilor Chambers said it would be taken up at the next meeting of the

Audit and Appropriations Committee.

The expenses for the 104th Annual Session, May 2-5, Macon, were approved and Local Arrangements Committee Chairman Golsan reviewed the planning and arrangements for this meeting.

Secretary-Treasurer Poer gave an explanation of the '52-'53 audits of Association finances and pointed out for information the difference in a cash basis (1952) and an accrual (1953) method of bookkeeping.

Councilor Yeomans asked that Council instruct the Secretary-Treasurer to publish a complete financial audit for the years, 1952, 1953 and 1954. Dr. Yeomans further stated that this should be published as soon as possible in the Journal and that it was understood that the year 1954 would be delayed until the year were completed. Secretary-Treasurer Poer seconded Councilor Yeomans motion and it was so voted.

Councilor Dougherty gave a report for information only on the annual meeting of the Society for Crippled Children.

Secretary-Treasurer Poer and President William Harbin made a motion to pass on an Executive Committee recommendation concerning life membership eligibility. A motion was made to accept the following recommendation as submitted to Council by the Executive Committee of Council and it reads as follows:

"1. Those physicians recommended by their County Societies for life membership to the House of Delegates at this 1954 Annual Session shall have full privileges of membership, attend all sessions and have voting privileges.

"2. That these same physicians be recommended to the House of Delegates for life mem-

bership at the 1954 Annual Session.

"3. That all county society secretaries be notified that any member recommended for life membership to the House of Delegates in the future must be in good standing, having paid his dues by January 1 and not in arrears as of April 1."

The motion carried.

Secretary Poer brought up the matter of conforming to the AMA system on classification of membership and it was agreed that the Council at their next meeting consider the necessary changes for this plan and recommend said changes if approved to the Constitution and By-Laws Committee.

It was moved, seconded and the motion carried that Council recommend to the Constitution and By-Laws Committee a change in the MAG Constitution and By-Laws to make the office of Secretary-Treasurer into two separate offices, i.e., Secretary and Treasurer.

Secretary-Treasurer Poer asked that a standing vote of gratitude be given to the members of Bibb County Medical Society and the Local Arrangements Committee for their excellent work in the preparation and planning of the 104th Annual Session of the MAG. Dr. Poer's recommendation was seconded and the motion carried.

Executive Secretary Mr. Krueger reported that

as far as could be ascertained at the present time the financial income of the Association from the Exhibitors at the 104th Annual Session would, in all probability, balance the expenditures of the Association in this connection.

Councilor Dougherty who is in charge of both commercial exhibits and scientific exhibits for the 104th Annual Session wished to state for the record that a sizeable increase in both commercial exhibits and scientific exhibits was accepted.

Edgar Woody, Associate Editor of the MAG Journal, called attention to some of the new features now being carried in the Journal. All of these features were approved by Council and Editor Poer and Associate Editor Woody were commended by Council for the excellent job they were doing in connection with the Journal.

Council recommended to the Tellers Committee that the voting hours for the 104th Annual Session be extended to 7 p.m. on Monday and Tuesday nights and the motion carried.

Professional conduct problems were discussed for information only.

Chairman Cheves asked for a motion to adjourn and the motion was made and duly seconded and carried and the meeting was adjourned at 12:10 p.m.

First Meeting of the 1954-1955 MAG Council

May 5, 1954 Macon, Georgia

The first organizational meeting of the 1954-55 Council of the Medical Association of Georgia was called to order at 3:30 p.m. in the Walter Little Room, Dempsey Hotel, Macon, May 5, by President Peter B. Wright.

Members present were: H. L. Cheves, Union Point; W. Bruce Schaefer, Toccoa; W. G. Elliott, Cuthbert; J. W. Chambers, LaGrange; G. W. Dillinger, Thomasville; Mark S. Dougherty, Jr., Atlanta; D. Lloyd Wood, Dalton; Clarence B. Palmer, Covington; H. Dawson Allen, Milledgeville; William Harbin, Rome; Peter B. Wright, Augusta; Willard R. Golsan, Macon; Neal F. Yeomans, Waycross; Milford B. Hatcher, Macon; and David Henry Poer, Atlanta. Also present was Mr. Milton D. Krueger, Executive Secretary.

The first order of business was the election of a chairman. Harry L. Cheves was nominated and seconded and duly elected. W. G. Elliott was elected vice-chairman. Council then elected to the Executive Committee H. Dawson Allen, Jr., and J. W. Chambers.

Council voted to instruct the secretary-treasurer to pay routine expenditures of the MAG Headquarters office and formally approved routine expenditures of the office. This includes authorization of travel expenses of two delegates to AMA meeting in San Francisco, June 21-25, and expenses of the Secretary or Executive Secretary to the same meeting.

Council voted to meet on June 6th.

The meeting was adjourned.

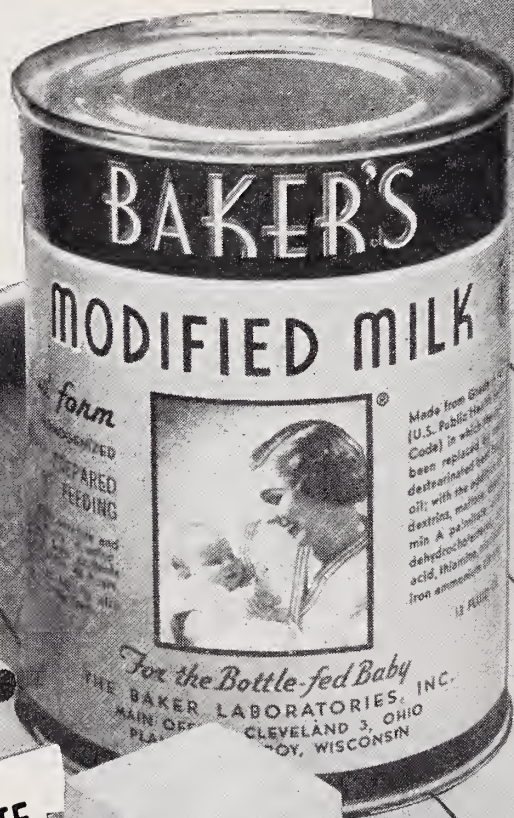
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Norepinephrine

in Myocardial Infarction

THE OCCURRENCE OF shock following an acute myocardial infarction is a common and a serious problem. The characteristic findings include cold, clammy skin, profuse perspiration, weakness, pallor or cyanosis, a rapid pulse and a marked fall in blood pressure. The prognosis for patients who develop this complication is grave, mortality rates as high as 30 per cent having been reported. However, during the past three or four years specific "antishock" measures have been developed and are already demonstrating beyond doubt that this mortality rate can be considerably lowered. The measures consist largely of the clinical use of various vasopressor drugs, typical of which is norepinephrine.

Norepinephrine or arterenol, an amine which is chemically closely related to amine which is chemically closely related to epinephrine, occurs normally in the human body, where it plays an integral part in physiologic vascular function. It produces an overall arterial, capillary, and venous vasoconstriction, thereby increasing peripheral resistance, bringing about an increase in systolic and diastolic systemic and pulmonary arterial blood pressure. It produces these effects without causing elevation of the pulse rate, increase of cardiac output, or the anxiety and apprehension that follow the use of epinephrine. It possesses the necessary rapidity of action and of inactivation to make it suitable for therapeutic use in acute hypotension.

It should be stressed that vigorous treatment of the shock that accompanies myocardial infarction must be begun early, for it has been clearly shown that the promptness with which measures

for combating shock are instituted is a key factor in recovery. Ordinarily a systolic blood pressure of 80 mm. in the average case or 100 mm. in a previously hypertensive case, if other evidence of shock is present, is an indication for emergency treatment.

Norepinephrine is available commercially, being supplied in ampuls of four cc. of 1:1000 solution. It must not be given subcutaneously or intramuscularly, but is administered, after dilution, as a slow intravenous drip. The contents of one ampul is added to 1000 cc. of five per cent glucose. This solution is then given either through a carefully placed needle or a polyethylene tube in the antecubital vein. The rate of flow at first should be about ten drops per minute and the blood pressure should be checked every two minutes. The flow is then adjusted to a rate that will maintain a systolic pressure of 100 to 120 mm. of mercury, and the patient's blood pressure is then checked at about five minute intervals. There is considerable individual variation, but the average adult will require a rate of from 20 to 30 drops per minute. In some patients it may be necessary to add several ampuls to the infusion, particularly in (a) those not responding to smaller dosage and (b) those in whom fluid restriction is desirable because of cardiac failure or oliguria. After the blood pressure has been stabilized for several hours, the dosage is gradually reduced and then discontinued. Abrupt cessation of treatment may result in a sudden drop in pressure. For this reason, Blumgart has recommended following the norepinephrine with slow "intravenous infusion of five per cent glucose in

Notes on practical aspects of cardiovascular diseases . . .
a monthly contribution of the Georgia Heart Association.

water for an additional 12 to 24 hours in order to facilitate emergency therapy if needed." Continuous administration of the drug over a period of several days may occasionally be necessary before a patient can maintain his own blood pressure.

Some words of caution are in order. Because norepinephrine has such a marked vasoconstrictor effect, great care must be taken to prevent extravasation of the solution into the subcutaneous tissues. If this occurs, the patient experiences excruciating pain and a slough of the tissues is likely to follow. This is particularly likely to occur if the veins of the hand or foot are used. As a matter of fact, even when the needle is well in

the vein, local venospasm, pallor and cyanosis may occur and subsequently thrombophlebitis may develop. The use of warm packs at and above the level of the needle has been advised as a means of decreasing the incidence and severity of cutaneous complications. It is essential that *a patient never be left unattended while receiving this drug.*

It should not be necessary to point out that the use of norepinephrine or other pressor amines, such as mephentermine, is not a substitute for, but rather an adjunct to the usual methods of treating the shock of coronary thrombosis. Relief of pain, oxygen, rest, reassurance, and other measures are still of great importance.

Medical Care for Dependents of Military Personnel

At the request of the Defense Department, Congress is considering a bill to expand and make more uniform the medical care program for civilian dependents of military personnel. It could have significant impact on the practice of medicine and on medical economics.

The department's bill states that dependents should receive private medical care only when military facilities are unavailable or inadequate. The AMA's policy, adopted after long study of the problem, is that dependents should be cared for in military hospitals and by uniformed physicians only when civilian care is inadequate or unavailable.

There is almost complete agreement that the present patchwork dependent medical care program should be changed to make benefits uniform geographically and within the services, and to spell out the benefits in law. The issue is whether the military medical services should care for all qualified civilian dependents, or dependents should, like the rest of the population, get their medical care from civilian physicians and hospitals.

Under the bill, medical care furnished by or underwritten by the federal government would be limited to "diagnosis, acute medical and surgi-

cal conditions, contagious diseases, immunization, and maternity and infant care." Dental care would be allowed only in emergencies or as an adjunct to medical care. These restrictions would be waived overseas and at remote stations in the United States.

The definition of "dependents" would not extend beyond parents and parents-in-law, and these relatives would have to receive at least half their support from the military member to qualify.

The Secretary of Defense would decide what charges, if any, to levy against dependents treated at military facilities. When treated privately, the dependents would pay the first \$10 cost of any illness, plus not more than 10 per cent of the total cost. The secretary could make use of voluntary health insurance for dependents if this system were found to be more economical.

As originally drawn, the bill would virtually exclude all clinics and hospitals except those operated in conjunction with prepaid insurance plans. During the hearings, Mr. Wolverton indicated he would be willing to drop this restriction. If this were done, the law then would offer benefits to all—fee-for-service physicians and groups as well as "closed panels."



Wine in Geriatrics?

"Wine is the nurse of old age..."

—Galen

SINCE long before the time of Galen, wine has been recommended not only for its epicurean delights but for its value in medicine—notably as an aid in combating the physical and emotional infirmities of old age.

This historical application, now supported and expanded by recent laboratory and clinical research* in American medical centers, is important to modern geriatricians—to physicians who today are giving added years of life to their patients, and who are asked to make these added years pleasant and comfortable.

New investigations have demonstrated, both in the laboratory and in the clinic, that the moderate use of wine can increase the appetite in anorexia.

They have shown that wine in judicious quantities can stimulate the lax and achlorhydric stomach of the elderly, assist in providing a more adequate fluid intake, and improve elimination by enhancing the important gastrocolic reflex.

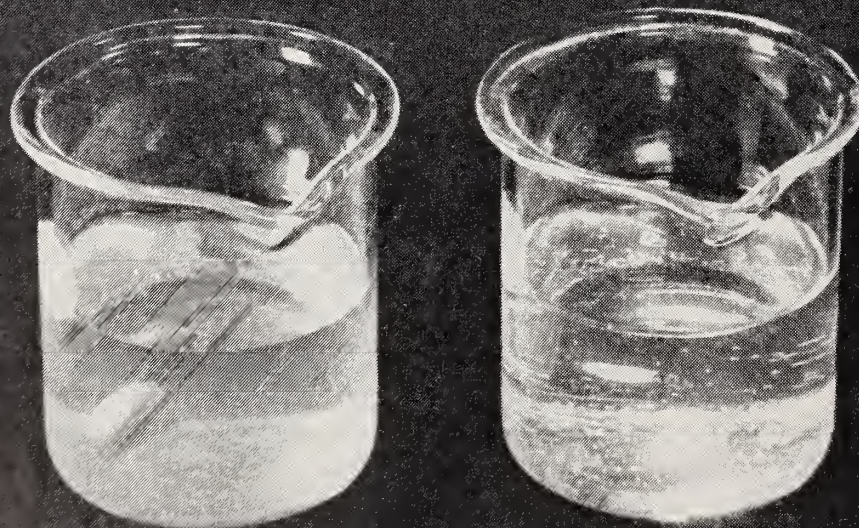
As a gentle sedative—sometimes called the safest of all sedatives for old age—wine can help allay restlessness and irritability, easing the fears and anxieties of the elderly. The euphoria—the “glowing sense of well-being”—produced by a glass of Port, Sherry or table wine, may aid significantly in overcoming the all-pervading sense of uselessness which too often mars the last decades of life.

Physiologically, wine acts gently and moderately as a vasodilator, diuretic, relaxant, and aid to nutrition and digestion. But perhaps of equal importance, it acts psychologically as well—as a mark of “something special” to grace the diet of the aging patient.

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*Research information on wine is available upon request.

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3:15—Disintegration Test begins in actual stomach fluids (pH 2.7). Beaker at left contains ordinary enteric-coated erythromycin. At right is new Film Sealed ERYTHROCIN Stearate (Erythromycin Stearate, Abbott).

Earlier Blood Levels *from*

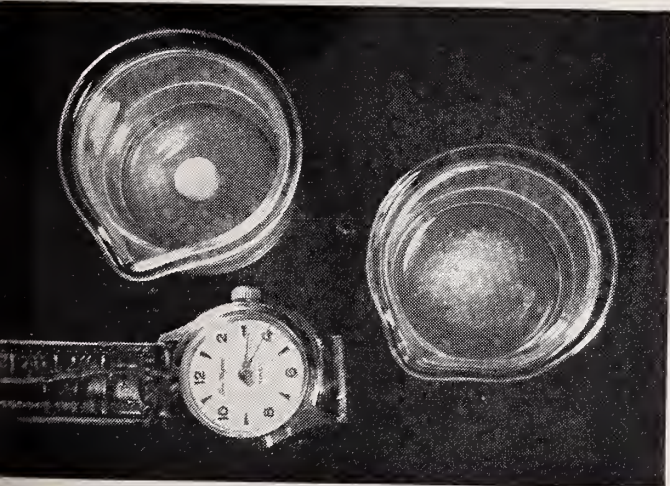


ERYTHROCIN

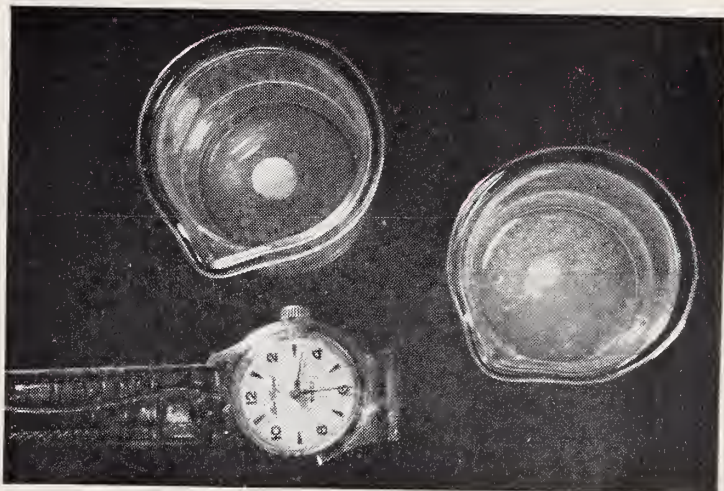
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HIGH BLOOD CONCENTRATIONS WITHIN 2 HOURS



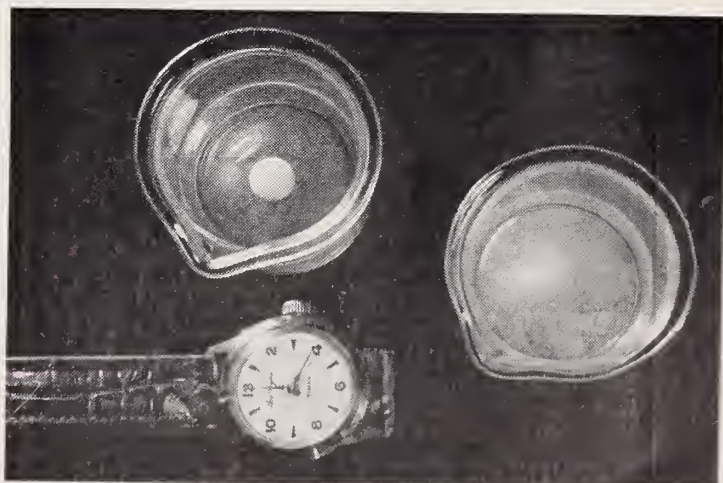
2:00—Five minutes later, Film Sealed coating has already started to disintegrate. The tissue-thin film actually begins to dissolve within 30 seconds after patient swallows tablet.



3:30—Film Sealing is now completely dissolved. At this stage, ERYTHROCIN is ready to be absorbed, and ready to destroy sensitive cocci—even those resistant to most other antibiotics.



4:05—Now the Film Sealed tablet mushrooms out with all of the drug available for absorption. Note that enteric-coated tablet is still intact. Tests show that the new Stearate form definitely protects ERYTHROCIN against gastric acids.



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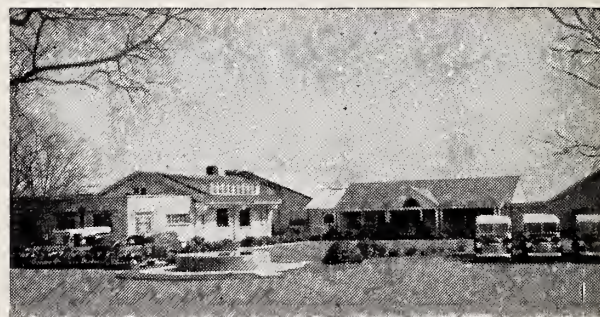
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abstracts by georgia authors

Corpe, R. F.; Parr, Luther H., Rome. "Pulmonary Torulosis Complicating Pulmonary Tuberculosis Treated by Resection," J. Thoracic Surg. 27:392-398 (Apr.) 1954.

The patient had proven tuberculosis and responded very well to bed rest, pneumoperitoneum, streptomycin and PAS. After nine months of this therapy, he left the hospital.

In the following eight months, one area of disease reactivated, forming a tuberculoma. The patient was readmitted. The sputum remained negative even following excavation of the solid lesion.

Surgical excision and subsequent pathological and bacteriological studies proved that this was cryptococcosis.

This is the only instance we have been able to find, after an extensive review of the literature, showing cryptococcosis and pulmonary tuberculosis in a living patient, who had either or both of the lesions treated surgically.

Melnick, Joseph L., Emmons, Jean, Opton, Edward M. and Coffey, Joseph H., Communicable Disease Center, Public Health Service, U. S. Department of Health, Education and Welfare, Atlanta. "Coxsackie Viruses from Sewage, Methodology Including an Evaluation of the Grab Sample and Gauze Pad Collection Procedures," Am. J. Hyg. 59:185-195 (Mar.) 1954.

Methods for the recovery of Coxsackie (C) viruses from dilute suspensions such as represented by sewage were investigated. The method of choice for the preparation from raw sewage of inocula for mice consisted of: (a) addition of protein (1.5 ml. horse serum per 100 ml. sewage), (b) saturation with ether, (c) precipitation of protein plus virus by half saturation with ammonium sulfate, (d) dialysis to remove salts and redissolve the precipitate, (e) concentration of virus by ultracentrifugation.

The gauze pad method, in which the pad is allowed to soak in flowing sewage for several days, yielded a significantly higher percentage of positive tests for virus than the grab sample method.

Melnick, Joseph L., Emmons, Jean, Coffey, Joseph H., Schoof, Herbert, Communicable Disease Center, Public Health Service, U. S. Dept. of Health, Education, and Welfare, Atlanta. "Seasonal Distribution of Coxsackie Viruses in Urban Sewage and Flies," Am. J. Hyg. 59:164-184 (Mar.) 1954.

Consecutive tests for up to four years for Coxsackie viruses in urban sewage and flies have been carried out in six states: Arizona, Connecticut, Kansas, Michigan, New York, and West Virginia. A total of 1,929 tests has been carried out, of which 269 yielded virus.

In almost every urban area studies, virus appeared in some of the specimens collected in the summer and fall, and then disappeared during the winter and spring. Virus was detected in the community during the cold months but was not widely disseminated, for it was only a rare winter specimen that yielded virus. Even though present each summer, the frequency of virus recovery during the months of peak occurrence varied in the same community from year to year, ranging from 10 to 50 per cent and over. The recovery of Coxsackie viruses was more regular from sewage than from flies.

In general, the strains isolated have yielded only myositis in infected infant mice. However, a number of strains isolated in Charleston, W. Va., during 1952 were neurotropic and myotropic. In addition to 23 strains which this dual tropism, 14 strains had lesions restricted to the skeletal muscles and seven strains produced lesions only in the brains of the mice examined.

In Muskegon, Mich., where 34 strains were isolated in one year, 26 belonged to a single antigenic type. However, two strains have been found in the same specimen, in eight of 80 isolates which have been studied for this purpose. In Topeka, Kans., it was found that Coxsackie viruses were recovered through the summer and fall of one year, but that one type was present in the summer and that it was replaced by a second type in the fall. Thus the long persistence of

virus for several months in a residential area, or its reappearance after a short period, may be due to the serial dissemination of new types of virus rather than to recurring waves of infection by the original virus.

Virus has been found in the influent and effluent flow at sewage disposal plants. However, on some occasions it has not survived in detectable amounts the trip to the plant, for it was recovered from several residential areas in Topeka when the sewage at the disposal plant was negative.

In only one area, Charleston, between June and August, 1952, were sufficient data available to compare recovery of virus from flies taken in bait traps as against those taken in cone nets. There was no significant difference between the two methods of trapping: five of 33 bait trap collections yielded virus, as did six of 29 cone net collections.

Lowance, M. I., Emory University School of Medicine. "Present Day Treatment of Asthmatic Patients," Sou. Med. J. 47:327-330, 333-334 (Apr.) 1954.

What can the 1954 allergist do for the asthmatic that the pediatrician, the otorhinolaryngologist, the general practitioner, the internist, or even the patient himself, cannot do? At first glance, one is inclined to answer "nothing," since today all treatments are common knowledge and available to the public as well as to the doctor. The Allergist, however, like any other specialist, who has focused his full attention on a particular condition, is better able to interpret, evaluate, and treat it.

The victim of a stubborn allergic disorder requires much detailed observation. He may be sensitive to emotional stress, affected by glandular functions, physical stimulæ, climate, temperature changes, et cetera; and the specialist is equipped to provide this kind of detailed care, correlating the drugs and procedures indicated.

In answer to the question, then, may we say that today's Allergist can offer the patient his ability, born of concentration on a particular disease; his soundness of judgment, based on much experience with this condition, while the confidence that his specialized knowledge inspires in the patient is an all-important by-product.

Lipton, H. R., Emory University School of Medicine. "Psychiatry Today, Post-Traumatic Psychiatric States," Bull. Fulton Co. Med. Soc. 28:44-45 (Apr.) 1954.

Various types of mental disturbances may follow head injury. The severity of the mental disturbance does not always correspond to the intensity of the trauma. The symptoms associated with prolonged disability, following head injury, whether the injury has been severe or mild, are predominantly mental symptoms related to anxiety. The post-traumatic syndrome is one of the most perplexing problems of medicine. Headache, dizziness, easy fatigability, tremors, inability to concentrate, disturbance of sleep, dyspepsia, nervousness, irritability, and emotional depression are so commonly present after head injuries that when they are present in the first few weeks or months they are spoken of as post-concussional or post-contusional symptoms. When they persist for many months, however, they are labeled post-traumatic syndrome.

Elderly people, nervous people, and patients with severe concussion are more liable to be subject to a severe post-concussional syndrome. The typical symptoms of post-traumatic concussional state are: impairment of memory; fatigability, mental and bodily; hypersensibility; vasomotor and emotional instability; headache, particularly after exertion; and dizziness of various degrees. The symptoms in post-traumatic psychoneurotic states have an expressive coloring; the patient exaggerates his suffering and incapacities. His complaints are often vague and have a symbolic meaning.

Petrie, Lester M., Dept. of Public Health, Atlanta. "Provision of Medical Services for Small Industries," Sou. Med. J. 47:338-342 (Apr.) 1954.

Medical service for small industries is a prime responsi-

bility of each of three groups (employers, employees, and the professions). No one should be discriminated against and no one should dominate. Physical examinations of all personnel not only find cases of hidden disability but also appraise abilities. If business and industry do their part, previously unrecognized patients with incipient disease will be found and referred to the practicing medical profession. It is more economical to find these cases early while they can continue in their jobs and pay for treatment out of earned income than to delay until disability makes them public liabilities. The internist through preventive medicine inside the plant attempts to discover and control causes of disability while the traumatic surgeon applies his skills to correct disabilities after they have occurred. The paper gives documental proof that the program being developed in Georgia was conceived in the minds of leaders in the Council on Industrial Health of the American Medical Association as interpreted in Georgia by such men as the late Dr. C. W. Roberts, Dr. Dick Newberry and Dr. James Edgar Paullin. The most recent development is the organization of the Industrial Health Council of Greater Atlanta, Incorporated.

McClure, J. N., Jr., Emory University School of Medicine. "Rupture of the Pregnant Uterus Due to Nonpenetrating Abdominal Trauma," *Surgery* 35:487-490 (Mar.) 1954.

Rupture of the pregnant uterus due to nonpenetrating abdominal trauma is rarely encountered even in large hospitals with active emergency services. A case is reported in which a 16 year old unmarried Negro female, four months pregnant, was in an automobile accident and sustained multiple injuries including lacerations of the face, a cerebral concussion, nonpenetrating abdominal injuries and a fracture of the right femur. She was given emergency treatment and observed carefully. Seventeen hours after admission to the hospital the abdomen was explored through a left subcostal incision for a possible ruptured spleen. Instead, a rupture of the uterus was encountered with the fetus and placenta free in the peritoneal cavity. The original incision was extended downward across the right rectus muscle and the uterus was repaired. The postoperative course was uneventful. One week later the fractured femur was fixed with an intramedullary nail.

Howell, S. C., Emory University School of Medicine. "The Craniostenoses," *Am. J. Ophth.* 37:359-379 (Mar.) 1954.

Blindness caused by premature synostosis of the cranial sutures has commanded the interest of ophthalmologists and neurosurgeons alike for the past half century or more.

Aside from the many discomforts and disabilities to which these people are subjected during life, none has lived to the usual expectancy.

Classification of the disease satisfactory to all observers has not yet been produced.

The cause is believed to be variation in the development of structures derived from the mesenchyme. Variations in skull structure thus may be associated with changes such as syndactyly, webbed fingers or toes or the absence of a hand or foot.

Treatment to prevent blindness and mental deterioration is surgical. Such treatment is directed at producing artificial suture lines in the skull to replace those which have prematurely closed thus permitting the skull contents to grow. Recent changes in technic have greatly increased the possibility of improvement.

To be effective surgery must be instituted early; during the first year of life if possible, and even as early as 6 months of age. This places the responsibility for early diagnosis on the ophthalmologist, pediatrician or general practitioner.

Foraker, Alvan G., Denham, Sam W. and Aguilar Celi, Polines-tor, Emory University School of Medicine. "Localization of Sites of Dehydrogenase Activity in the Cervix Uteri: Normal, Metaplastic, and Neoplastic Epithelium and Cervicitis," *Cancer* 7:311-317 (Mar.) 1954.

Fifteen cases of carcinoma of the cervix, and 37 specimens of non-neoplastic cervical lesions were studied for sites of dehydrogenase activity. The distribution of this enzyme has been found to correlate with sites of cell growth (including cancer) and active cell function in various contexts. Evidence of dehydrogenase activity correlated closely with sites of growth in normal and abnormal epithelium, as seen

in this series. Proliferating squamous cells in invasive carcinoma, intraepithelial carcinoma, epidermidization, metaplasia and normal cervical epithelium all gave evidence of enzyme activity. Dehydrogenase activity corresponded closely to regions of conventionally demonstrable cellular activity and growth.

Williams, R. C., Georgia Dept. of Public Health, Atlanta. "Coordinated Health Services of Community Hospitals and Local Health Agencies in Georgia," *Sou. Med. J.* 47:342-350 (Apr.) 1954.

There has been a slow but significant trend in Georgia within recent years towards voluntary cooperation between hospitals and local health units in meeting the health needs of the community. The integration and coordination is described that has taken place in four areas in the state between local health departments and community hospitals: Augusta, Brunswick, Columbus and Decatur. Emphasis is placed on the fact that present day public health activities involve an increasing amount of clinical service and that these required services are best made available through out-patient clinics located in or near hospitals. To avoid useless duplication of expensive equipment, for fuller utilization of scarce hospital beds and health personnel, and to insure satisfactory service to patients, effective coordination must be further developed. The precise methods of securing this coordination will vary according to local needs and conditions. The program should be voluntary and characterized by considerable variation with respect to the type and extent of service provided, personnel, facilities and funds available. Programs for effective coordination of local health departments and public hospitals are in the early stages of development. By common understanding and careful planning, much progress can still be made.

Mullen, S. A. and Foraker, A. G., Emory University School of Medicine. "Intra-epithelial Cancer in Pregnancy," *Obstet. & Gynec.* 3:274-282 (Mar.) 1954.

A case report is employed in order to illustrate the problem of intraepithelial carcinoma of the cervix during pregnancy. Carcinomatous changes were found to persist in this patient in several cervical biopsies obtained during pregnancy as well as six weeks and six months postpartum. However, examination of the entire cervix following hysterectomy seven months postpartum failed to reveal any residual carcinoma. It is concluded that intraepithelial carcinoma of the cervix encountered in pregnancy requires careful study and prolonged follow-up before radical therapy should be undertaken. Since even the morphologic characteristics of intraepithelial carcinoma of the cervix during pregnancy are the subject of controversy, the opinions of five prominent consultants on this case are recorded.

Krainin, M. J. Whitner, V. S. and Merrill, A. J., Emory University School of Medicine. "A Simple Indirect Method for Determining Plasma Sodium Levels," *J. Lab. & Clin. Med.* 43:482-488 (Mar.) 1954.

Great ionic concentration gradients of sodium and potassium exist between erythrocyte and plasma. Water apparently moves freely between these compartments responding to osmotic changes. Since sodium exercises primary control of osmotic stability of the extracellular fluid, it was decided to investigate the relationship between erythrocyte volume and plasma sodium concentration. Bloods were obtained from 60 patients having wide variations in plasma sodium concentrations. A straight line relationship was noted between erythrocyte volume and plasma sodium concentration. From this a simple method for determining plasma sodium was derived. This consists in comparing the average value of duplicate hematocrits (H'_{crit}) with that obtained after replacing part of the plasma in the above hematocrit tubes with two solutions of different tonicities (H'_{crit_1} , H'_{crit_2}).

The value $Y = \frac{H'_{crit_0} - H'_{crit_1}}{H'_{crit_2} - H'_{crit_1}}$ is obtained. Using (Y), the

sodium concentration is read from a curve. Using the blood from the patients noted above, the curve was derived by plotting their (Y) values against the plasma sodium determined by flame photometer. Coefficient of correlation was .94; the standard deviation, ± 3.2 mEq/L. This simple procedure makes sodium determinations available to large segments of the medical profession who do not have access to the flame photometer. The principles, the implications, and the above method are discussed.

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"It is strange," Malleson says, "how little clinical recognition" has been given to the "negative behavior" or "endogenous misery" of the woman with endocrine imbalance. Largely accountable for this, of course, is the patient's own reluctance to discuss these symptoms with her physician until she actually suffers from some of the more obvious menopausal symptoms such as hot flushes. Even then she may become so accustomed to her change in feeling she can't remember what it's like to feel well.¹

Changes in the mood pattern are just a few of the many distressing symptoms of declining ovarian function which are so often disguised because they do not always coincide with cessation of menstruation, and at times will occur long before, and even years after. Other good examples are insomnia, headache, easy fatigability, arthralgia — and understandably so, when one considers that the loss of ovarian hormone "withdraws one of the most important metabolic regulators of the organism."²

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1. Malleson, J.: *Lancet* 2:158 (July 25) 1953. 2. Goldzieher, M. A., and Goldzieher, J. W.: *Endocrine Treatment in General Practice*, New York, Springer Publishing Company, Inc. 1953, p. 23.

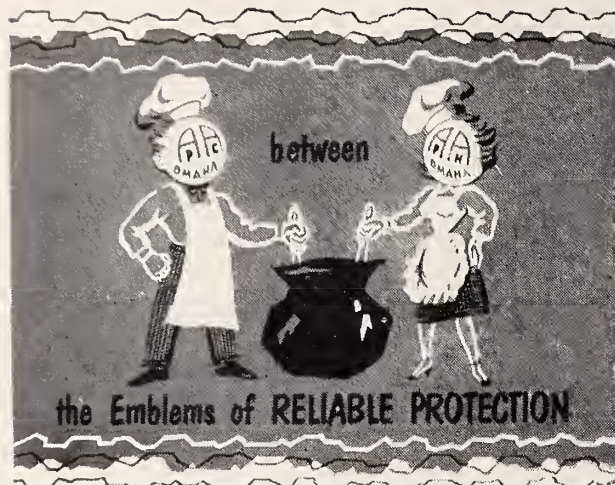
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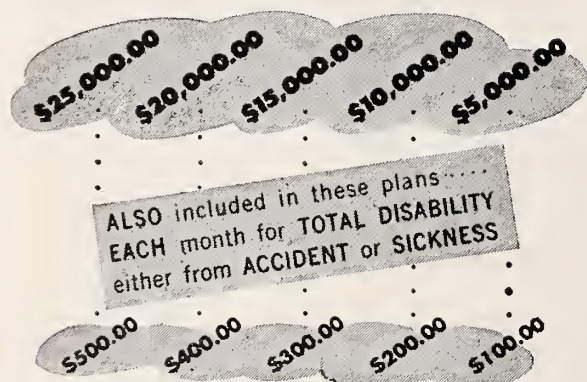
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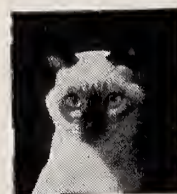
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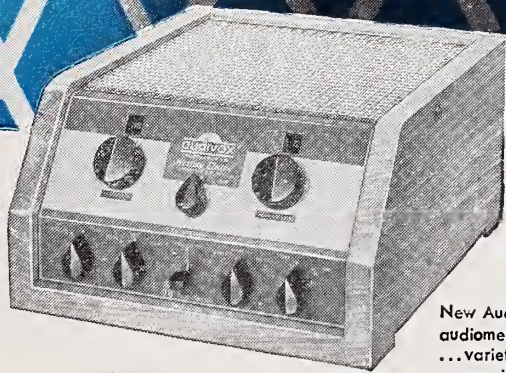
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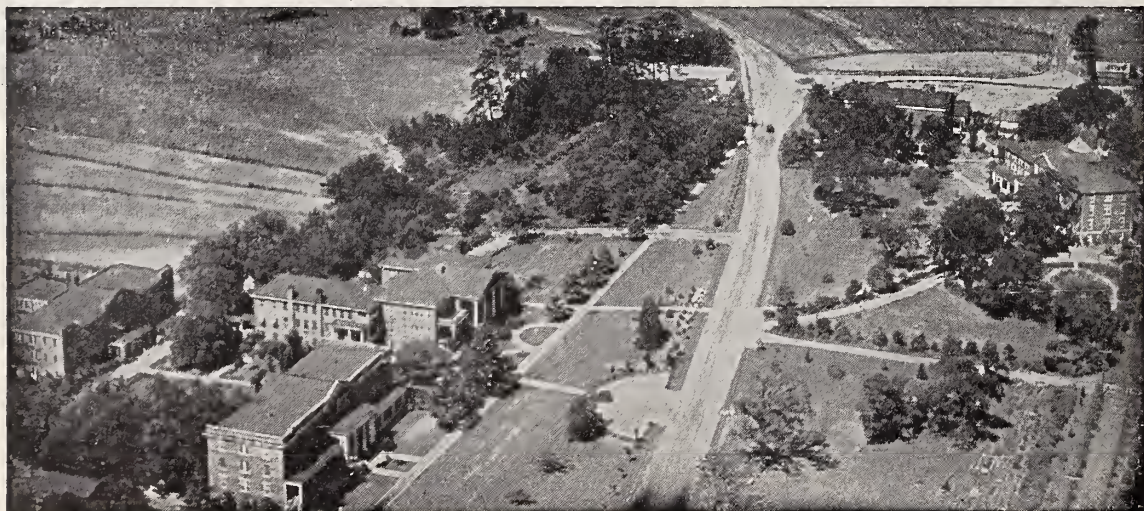
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doctor placement page

AVAILABLE PHYSICIANS

Regester, W. D., M.D., St. Luke's Methodist Hospital, Cedar Rapids, Iowa, interested in obtaining a location suitable for a partnership with Dr. R. L. Paddock, available July 1, 1954, general practice, graduate of College of Medical Evangelists in Los Angeles, Calif.

Sharpe, Joseph H., M.D., Roswell Park Memorial Hospital, Buffalo, N. Y., born Checotah, Okla., single, Episcopal, graduate University of Oklahoma, 1947, residency at VA Hospital, New Mexico, General Hospital, New York, reserves USN, specialty general surgery, desires community in Georgia, available August 1, 1954.

Albea, John M., M.D., Apt. 108, E. Wherry, Fort Campbell, Kentucky, age 29, married, Protestant, graduate Tulane Medical School, 1952, presently an Army Medical Officer, interested in general practice in Georgia, available August 1, 1954.

Berry, Reginald V., M.D., US Naval Hospital, Pensacola, Florida, age 47, married, Protestant, graduate Yale Medical School, 1932, residency Duke University, North Carolina; U. S. Naval Medical Center, Maryland, interested in psychiatry and neurology in Georgia (clinic, assistant associate or institutional), available July-August 1954.

Coleman, Julian B., M.D., US Naval Air Facility, Weeksville, Elizabeth City, North Carolina, age 33, single, Protestant, graduate McGill University, 1952, priority 4, size of community not important, in clinic or as an assistant or associate, available July 15, 1954.

Fitz, Thomas E., M.D., 1053 Oakland Avenue, Rock Hill, South Carolina, age 32, married, 3 children, Presbyterian, graduate Duke University School of Medicine, 1949, specialty—internal medicine and cardiology presently in practice, wishes to relocate due to economic status, desires group or associate practice, available two or three weeks after location secured.

Hunter, Robert, M.D., Hartford Hospital, Hartford, Connecticut, age 32, married, Episcopal, graduate Columbia University College of Physicians and Surgeons, 1943, board eligible—ob-gyn, prefers small clinic or an association, available July 1, 1954.

Lamb, James W., M.D., 906 Monroe Street, Vicksburg, Mississippi, age 38, married, Baptist, graduate Tulane University School of Medicine, 1938, residency Kansas City General Hospital, 4 year fellowship in general surgery, priority 4, specialty—general surgery, available July 1, 1954.

Maxwell, George A., M.D., 818 Thayer Avenue, Silver Springs, Maryland, age 32, married, Presbyterian, graduate University of Maryland Medical School, 1944, residency Maryland General and St. Agnes Hospitals, passed Part I, American Board of Ob-Gyn, wishes to locate in a relatively small town where sailing is readily available, prefers associate, available anytime.

MacKavanagh, James L., M.D., 160 Marion Avenue, Marrick, L. I., New York, age 44, married, Roman Catholic, graduate Georgetown University Medical School, 1934, presently in general practice, wishes to relocate, priority 3, interested in general practice in Georgia, size of community not too important, available within two or three months after location is selected.

Taber, Richard P., M.D., Department of Pediatrics, University Hospital, Ann Arbor, Michigan, age 30, single, Presbyterian, graduate University of Rochester Medical School, 1948, residency Buffalo Children's Hospital, N. Y.; University Hospital, Michigan, priority 4, interested in pediatrics in Georgia, available July 1, 1954.

Allen, Raymond A., M.D., c/o Mayo Foundation, Rochester, Minn. Born November 6, 1921, Lyman, Utah, single, Mormon, graduate University of Louisville, 1946, assistant resident in pathology one year, New York City Hospital, Fellow in pathology three years, Mayo Foundation, interested in location in Georgia, available July, 1955.

Battle, William C., 1st Lt., USAF (MC), 6407th USAF Hospital, Peacom Air Base, APO 323, c/o Postmaster, San Francisco, Calif. Graduate Duke Medical School, 1949, surgical internship at Duke 1949-50, Pediatric internship at Long Island College Hospital, 1951-52, Board eligible in pediatrics, plan to take exams this year, currently completing a tour as pediatrician at the 6407th USAF Hospital, Tachikawa, Japan. Available July, 1954.

Bragg, Rudolph, M.D., 567th Medical Squadron, McChord Air Force Base, Washington. Age 28, single, Methodist, graduate Medical College of Georgia, 1952, license held in Georgia, interested in general practice as an individual or associate, in community under 10,000 in Georgia. Available July 1, 1954.

Ganl, Jack H., M.D., Lafayette Charity Hospital, Lafayette, La., age 31, single, Episcopalian, graduate Louisiana State University Medical School, 1952, rotating residency, Lafayette Charity Hospital, interested in general practice, in clinic or as an associate, available July 15, 1954.

Garner, J. W., M.D., Crawfordville, Ga., currently engaged in general practice, age 26, married, one child, Baptist, graduate Medical College of Georgia, 1949, 1½ years general practice residency, Charity Hospital 2A Classification, interested in general practice in Georgia, 2,000 up.

Gray, Henry T., M.D., 9-C Copeley Hill, Charlottesville, Va.; will complete residency in dermatology and syphilology in June of this year, will be Board eligible, most interested in an association with another dermatologist or a group, would not be opposed to solo practice.

Kinzer, Gilbert M., Lt. MC USN, Main Dispensary, USNAS, Corpus Christi, Tex., 30 years of age, B.A. degree Vanderbilt University, M.D. degree University of Tennessee, 1947, have a basic science certificate and medical license, owned and operated a small hospital in Caraway,

Ark. (GP-Surgery) took PG course in pediatrics at Harvard Postgraduate Medical School, called to active duty '51, graduated from School of Aviation Medicine, which gives special training in EENT, cardiology and physiology, desires to locate in South in a town with minimum 3,000 population, town must have hospital, plans to do general practice with obstetrics and limited major surgery, prefers an association with another doctor.

Moore, Melvin, M.D., 915 East 17th Street, Brooklyn, N. Y. Born January 5, 1924, married, Hebrew, graduate Chicago Medical School, 1946, certified by American Board of Radiology, residency, Newark Beth Israel Hospital, Queens General Hospital, specialty, Radiology, available March, 1954.

Lee, James Earl, M.D., Flower and 5th Avenue Hospital, Interns' Quarters, New York 29, N. Y., age 33, married, Protestant, graduate New York Medical College, 1954, draft exempt by previous service, interested in general practice in Georgia, available July, 1955.

Moseley, Robert W., M.D., 97th General Hospital, APO 757, c/o Postmaster, New York, N. Y., age 28, married, Christian, graduate Medical College of Virginia, 1948, residency Walter Reed Army Hospital, Board eligible for pediatrics. Available July 1, 1954.

Pattison, John D., M.D., FASRON 104 Det. 1, FPO, New York, N. Y., age 34, married, Protestant, graduate University of Pittsburgh, 1944, residency VA Hospital, service completed October 5, 1954, specialty internal medicine, clinic or group practice in Georgia, available one or two months after discharge.

Rutledge, James W., M.D., The John Gaston Hospital, Memphis, Tenn., age 29, married, Protestant, graduate New York Medical College, FFAH 1953, priority 4, served 30 months in USAAF, completing rotating internship at University of Tennessee, interested in general practice in Georgia, available July, 1954.

Sakol, Marvin J., M.D., 233 Ridgedale, Louisville, Ky., interested in internal medicine and hematology, completes residency in internal medicine in July and is particularly well trained in hematology.

Schiffett, Joseph Ray, M.D., US Naval Hospital, Jacksonville, Fla., age 29, married, one child, Protestant, graduate Baylor University College of Medicine, 1953, priority 4, interested in general practice in Georgia, available August 1, 1954.

Segal, Milton, M.D., 675 Dickson Parkway, Mansfield, Ohio, 34 years of age, certified radiologist, interested in practice of radiology in office, hospital or group.

Shea, Wm. H. H., M.D., 568th USAF Dispensary, McGuire Air Force Base, Trenton, N. J., age 33, married, Roman Catholic, graduate University of Maryland, 1951, priority 4, interested in general practice, available July 15, 1954.

Stark, C. V., M.D., Box 109, Arcadia, Fla., wants practice in Georgia during spring of the year only, as he spends

winters in Florida, born November 25, 1878, widower, graduate Oploma Medical University, Tenn., 1900, specialty—general medicine, population 1,000 or more.

McCree, Robert L., M.D., 504 Arey Ave., Albemarle, N. C., graduate of Meharry Medical College, 1946, two years residency—internal medicine, finished 3-year term in Army, since discharge have taken over practice of a classmate, who will return in August, 1954. Desires to establish himself in practice. Would like town with fairly large Negro population.

Bonner, Mack S., M.D., 133 Jackson Drive, Slocum Village, Havelock, N. C. Will be discharged from the Navy within next six to eight months; graduate Medical College of Georgia; licensed in Georgia; interested in general practice in which also might practice some anesthesia.

Brannon, R. A., Jr., M.D., Vicksburg Clinic, 1600 Monroe Street, Vicksburg, Miss. Interested in establishing practice in Dermatology and Allergy at Brunswick, Georgia. Board eligible in Dermatology; had seven years experience as a health officer.

Ewing, George B., M.D., LaFargeville, New York. 50 years of age; married; Methodist; graduate Vanderbilt Medical School, 1929. Presently in practice, desires change of climate; Priority 4; interested in general practice in community of 1500 to 2000 in Georgia. Available early fall.

Lloyd, Thomas S., Jr., M.D., Southern Baptist Hospital, 2700 Napoleon Avenue, New Orleans 15, Louisiana. Age 28; married, two children; Presbyterian; graduate Medical College of Virginia, 1948; priority 4; completing 3rd year residency of Ob-Gyn at Southern Baptist Hospital; available January 1, 1955.

McCorkle, Robert G., Jr., M.D., 350 South Fuller 4J, Los Angeles, Calif. Age 30; married; Catholic; graduate Baylor University School of Medicine, 1946; priority 4; specialty—Thoracic Surgery. Interested in association with another doctor. Available August 1, 1954.

Moseley, Charles H., M.D., 707 Duncan Avenue, Killeen, Texas. Graduate Medical College of Georgia, 1952. Desires to become associated with a competent general surgeon to assist in surgery and do general practice. Available July 1, 1954.

Psimas, James M., M.D., M.O.Q. H-2, Cherry Point, North Carolina. Age 30,

married, two children, Episcopal, graduate University of Virginia, 1948. Residency N. C. Baptist Hospital; St. Luke's Hospital, and DePaul Hospital. Specialty—Ob-Gyn only. Group preferred. Available September, 1954.

Schneider, Chas. F., M.D., VA Center, Biloxi, Mississippi. Age 36. Married, Lutheran, graduate University of Virginia School of Medicine, 1943; certified by the American Board of Surgery; presently in practice, desires private type practice; priority 4. Specialty—general surgery. Available 60 to 90 days notice.

Hendrick, James Wesley, M.D., 7030 Cohn Street, New Orleans, Louisiana. Age 30, married, Methodist, graduate University of Tulane Medical School, 1949. Will be board eligible Ob-Gyn in July, 1954. Specialty—Ob-Gyn; prefers assistant or associate. Available July 1, 1954.

Ingram, William, Jr., M.D., U.S. Naval Hospital, Oakland, Calif. Age 32. Married, Protestant. Graduate University of Georgia School of Medicine, 1946. Residency USNH, Philadelphia; St. Albans, N. Y.; Oakland, California. Specialty—Neuropsychiatry (Clinic or institutional). Available June, 1954.

Moore, George W. St. Clair, M.D., 101 Ardmore Avenue, Danville, Pa. Age 29. Married. Protestant. Graduate of University of Pennsylvania, 1948. Residency Geisinger Memorial Hospital and Foss Clinic. Specialty—Urology. (Clinic, Assistant or Associate). Available July, 1955.

Pool, Winford H., Jr., M.D., 152 Longview Drive, Lafayette, Louisiana. Age 27. Married, two children. Baptist. Graduate Medical College of Georgia, 1952. Interested in General Practice in Georgia in community of 5,000 to 20,000 (private or associate). Available July, 1954.

Rogers, Charles S., M.D., 3739 Locust Street, Philadelphia 4, Pa. Age 30. Married; Presbyterian. Graduate University of Pennsylvania, 1947. Residency University of Pennsylvania Hospital. Priority 5-A. Specialty—Surgery (General and/or thoracic). Any size community. Available July 1, 1954.

Shanahan, John Rush, M.D., 10310 Greenfield Street, Kensington, Maryland. Age 39. Married; Roman Catholic. Graduate Georgetown University, 1948. Residency U. S. Naval Hospital, Bethesda, Maryland. Priority 5. Specialty—Internal Medicine. Desires community in Georgia of 20,000 to 30,000. Available June, 1955.

AVAILABLE LOCATIONS

Dawsonville, Georgia—(Dawson County) Have a modern well equipped health clinic. Arrangements for an office can be made without difficulty. No physician in county. (pop. 500) Contact: Mr. Carlton Gilleland, Mayor City of Dawsonville, Dawsonville, Georgia.

Doraville, Georgia (DeKalb County). Hospital in nearby Chamblee, small clinic in Doraville for rent. New homes being built \$8,950.00 up. Grammar-high school. Social and recreational facilities. Population sufficiently large enough to support physicians. (County pop. 30,900). Contact: Mr. George W. Walker, City Clerk, Doraville, Georgia.

Villa Rica, Georgia (Carroll County) New 24 bed HB hospital to be built soon. Now have seven bed hospital. Office available for lease, reasonable. Housing available at reasonable cost. 12 grade accredited school. (Pop. 3,200). Contact: Mr. Edgar P. Candler, Villa Rica, Georgia.

Buchanan, Georgia—(Haralson County) No physicians in area; 20 bed hospital, not in use, may be purchased at give away price. Housing available rent or buy reasonably. Need two doctors to run hospital or clinic, as they so desire. Contact: Mr. P. G. Camp, Buchanan, Ga.

Americus, Georgia — (Sumter County) Population 11,367, county population—24,208. About to be without a practicing Negro physician; two Negro schools with an enrollment of 1355; two hospitals, 140 beds, 19 doctors; housing available reasonably; Americus is a very prosperous community with a large number of business establishments. Contact: Mrs. Emma G. Anderson, 213 Forrest St., Americus, Georgia.

Cumming, Georgia—(Forsyth County). Located 40 miles north of Atlanta on U.S. Highway 19. Office and clinic building now vacant that can be fixed immediately to suit one or two doctors, either with clinic, hospital or office set-up. As president of the bank in Cumming, in position to help young doctor get started. Good churches, schools, city clubs and living conditions. Population 2,500, county 15,000. Contact: Mr. Roy P. Otwell, Cumming, Georgia.

Physicians Being Released By Navy

Scott, James L., Jr., M.D., (June 14, 1954), 488 Pine St., Marietta, Georgia.

Shepherd, Mason H., M.D., (June 22, 1954), 1103 Milledge Road, Augusta, Georgia.

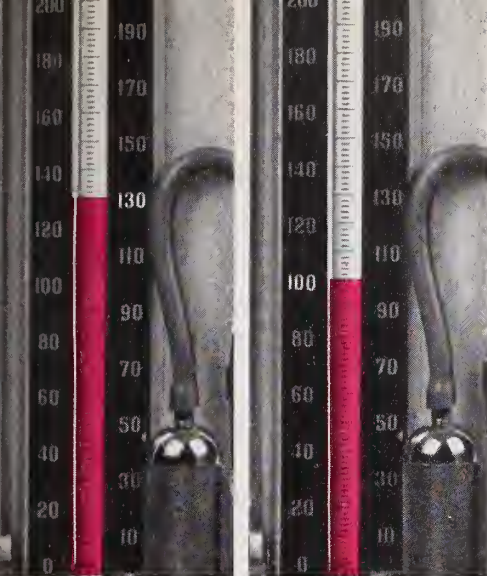
Wardell, Dock J., M.D., (June 26, 1954), R.F.D. 2, Americus, Georgia.

Carswell, Harold A., M.D., (June 30, 1954), Gracewood, Georgia

Kessler, Fred O., Jr., M.D., (June 30, 1954), 1219 East 48th St., Savannah, Georgia.

Griffith, Henry W., M.D., (June 30, 1954), 736 Peoules St., S.W., Atlanta, Georgia.

The following physician being released April 29, 1954, desires work or training in Georgia: Lt. Francis B. Adams, Jr., Naval Hosp., Mare Island, Vallejo, Calif. (home: 300 First South St., Seneca, S. C.) Type of work or training: General or Pediatric Surgery. Graduated 1948, Emory U., one year rotating internship.

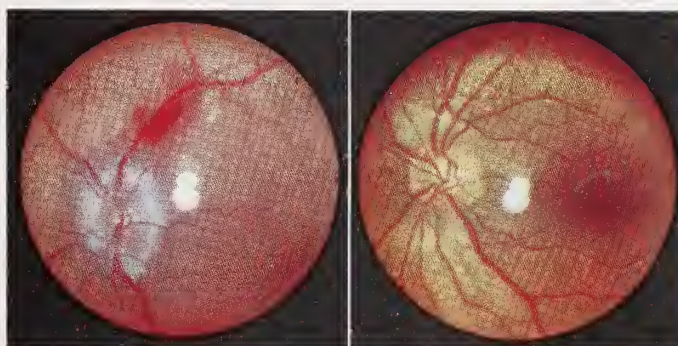


APRESOLINE REDUCES DIASTOLIC PRESSURE

Diastolic pressure reduced to level considered normal in one-quarter and to 110 mm. Hg or less in one-third of 97 patients receiving oral Apresoline for periods ranging from 3 months to 1 year or longer;¹ hypertension in which neurogenic or psychogenic mechanisms predominated most improved; patients with severe as well as moderate hypertension benefited.

APRESOLINE LESSENS RETINAL ARTERIOLAR CONSTRICTION, RETINAL HEMORRHAGES*

Lessening of retinal arteriolar constriction; disappearance of retinal hemorrhages; remittance of hypertensive headaches, giddiness, paresthesias, transient pareses, and encephalopathies; some evidence of improved mental alacrity.



APRESOLINE INCREASES RENAL BLOOD FLOW

Renal improvement less marked than cerebral improvement, but renal blood flow and filtration rate increased and hematuria and proteinuria remitted in some cases; hypertensive heart disease little improved and, in some cases, worsened.

Side Effects: Side effects "minor, transient, or remediable" in most cases.

Headache, gastrointestinal upset, periorbital and ankle edema, and a "grippe-like syndrome"—involving malaise and muscle and joint pain (see note)—observed.

Apresoline®

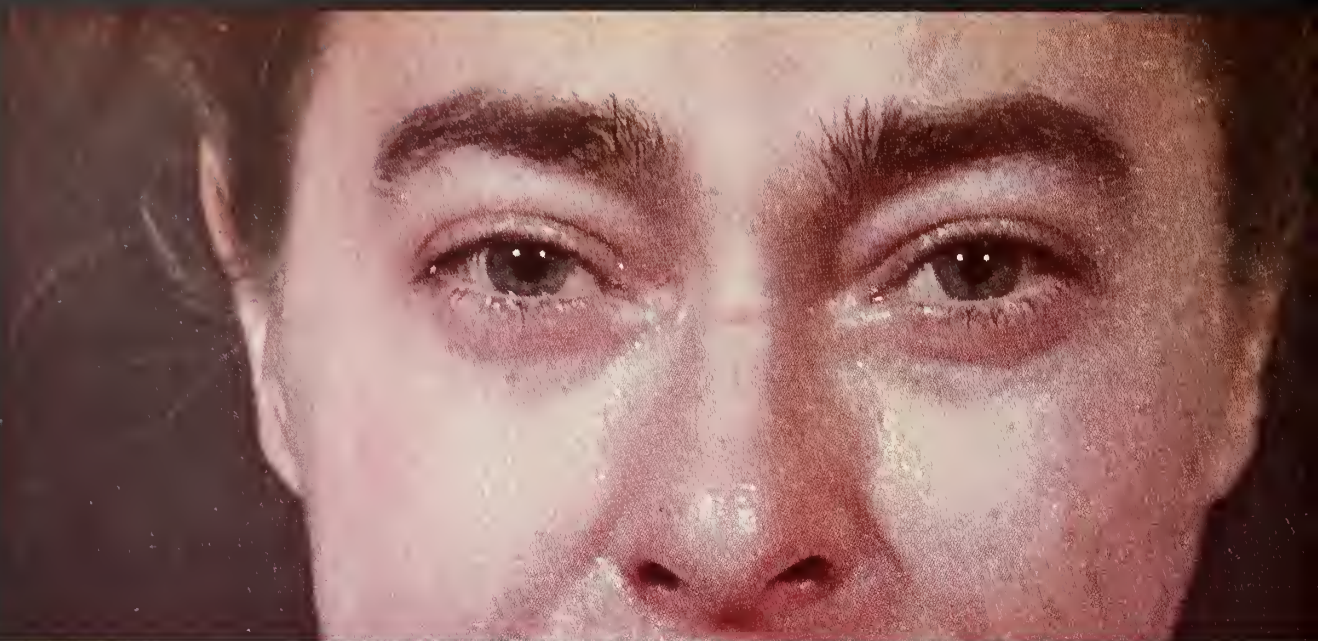
NOTE: Appearance of arthritis-like symptoms during Apresoline therapy is an indication for cessation of treatment. Experience has shown that the phenomenon remits spontaneously on withdrawal of the drug. These symptoms are not likely to occur in patients who receive a daily dose of 400 mg. or less.

FOR COMPLETE INFORMATION on Apresoline ask your CIBA representative or write Medical Service Division, CIBA Pharmaceutical Products, Inc., Summit, N. J. **SUPPLIED:** Apresoline hydrochloride (hydralazine hydrochloride CIBA) 10-mg. tablets (yellow, double-scored), 25-mg. tablets (blue, coated), and 50-mg. tablets (pink, coated) in bottles of 100, 500, and 1000; 100-mg. tablets (orange, coated) in bottles of 100 and 1000.

¹ TAYLOR, R. D., DUSTAN, H. P., CORCORAN, A. C., AND PAGE, I. H.: ARCH. INT. MED. 90:734 (DEC.) 1952.

*THE NORMAL FUNDUS (RIGHT) AS COMPARED WITH THE FUNDUS IN HYPERTENSION SHOWING EDEMA, EXUDATES, AND HEMORRHAGES (LEFT); ILLUSTRATIONS FROM "THE FUNDUS OF THE EYE": BEDELL, A. J.: CIBA CLINICAL SYMPOSIA 4:135 (JULY) 1952. THESE ILLUSTRATIONS ARE FOR DEMONSTRATION PURPOSES ONLY AND DO NOT REPRESENT APRESOLINE-TREATED PATIENTS.

C I B A



ALLEVIATES HAY FEVER, OTHER RESPIRATORY ALLERGIES

The above photos show a case of allergic rhinitis before and after Pyribenzamine therapy. Many such cases have been reported in the literature. A few examples: Loveless and Dworin¹ found Pyribenzamine beneficial in 82% of 107 patients; Feinberg² noted relief in 82% of 254 cases; Gay and associates³ in 76% of 51 cases; Arbesman and colleagues⁴ in 84% of 106 cases. In a later study Arbesman⁵ rated Pyribenzamine one of "the most effective of all the drugs studied in allergic rhinitis. . . ." *Side effects:* It has been stated that "undesirable symptoms from the use of 50 to 100 mg. doses of Pyribenzamine were rarely of sufficient severity to interfere with its use."⁶ Drowsiness, nausea, epigastric distress, vertigo and other side effects—rarely severe—may occur in some patients.

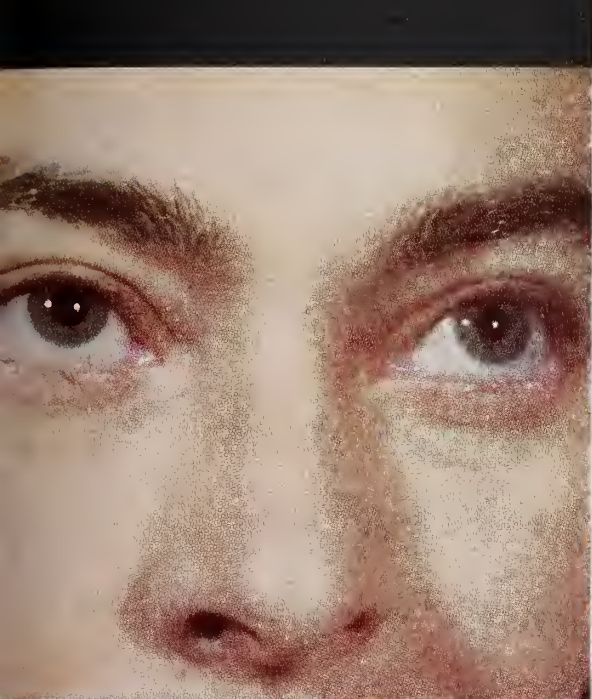
CONTROLS PENICILLIN REACTIONS

Pyribenzamine has been used successfully to control penicillin reactions—especially urticaria and itching. For example, Kesten⁷ found that oral Pyribenzamine relieved or suppressed post-penicillin urticaria in 16 of 18 cases; she termed it "a most useful agent in allergic symptoms which follow the administration of antitoxin or penicillin."

RELIEVES ALLERGIC DERMATOSES

Foster⁸ reported good results with oral Pyribenzamine in patients with various allergic dermatoses. In another study⁹ of 241 such patients, Pyribenzamine was found effective.





*Pyribenzamine 25-mg.
tablets now available—
for children and for adults
who can be maintained
on low dosage or
who experience side effects
from the usual dosage
of antihistamines*

**PUBLISHED CLINICAL STUDIES
SHOW THOUSANDS OF
ALLERGIC PATIENTS
RELIEVED BY**

Supplied: Pyribenzamine hydrochloride 25-mg. and 50-mg. tablets; Pyribenzamine Elixir, 30 mg. Pyribenzamine citrate (equivalent to 20 mg. tripeleppamine hydrochloride) per 4-ml. teaspoonful; Pyribenzamine hydrochloride solution (for parenteral use), 25 mg. per ml., in 1-ml. ampuls.

Pyribenzamine®

PYRIBENZAMINE HYDROCHLORIDE (TRIPLEPPAMINE HYDROCHLORIDE CIBA)
PYRIBENZAMINE CITRATE (TRIPLEPPAMINE CITRATE CIBA)

REFERENCES

1. Loveless, M. H., and Dworin, M.: J. Am. M. Women's A. 4:105 (March) 1949.
2. Feinberg, S. M.: J.A.M.A. 132:702 (Nov. 23) 1946.
3. Gay, L. N., Landau, S. W., Carliner, P. E., Davidson, N. S., Furstenberg, F. F., Herman, N. B., Nelson, W. H., Parsons, J. W., and Winkenwerder, W. W.: Bull. Johns Hopkins Hosp. 83:356 (Oct.) 1948.
4. Arbesman, C. E., Koepf, G. F., and Lenzner, A. R.: J. Allergy 17:275 (Sept.) 1946.
5. Arbesman, C. E.: J. Allergy 19:178 (May) 1948.
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7. Kesten, B. M.: Ann. Allergy 6:408 (July-Aug.) 1948.
8. Foster, P. D.: California Med. 73:413 (Nov.) 1950.
9. Morrow, G.: California Med. 69:22 (July) 1948.

For complete information on Pyribenzamine ask your CIBA representative or write Medical Service Division, CIBA Pharmaceutical Products, Inc., Summit, N. J.



INCREASES PERIPHERAL BLOOD FLOW:

Priscoline reported to be a valuable aid to conventional therapy in peripheral ischemia and its sequelae—pain, loss of function, ulceration, gangrene, other trophic manifestations; Priscoline most effective when vasospasm is prominent but may prove limb-saving even when vasospasm is minimal because it decreases vascular tone, promotes establishment of collateral circulation.

MULTIPLE ACTION:

Priscoline exerts direct vasodilating effect on vessel wall, blocks sympathetic nerves (probably at their terminations in vascular muscle), blocks vasoconstrictive action of circulating epinephrine-like substances.

Side Effects: Certain side effects of Priscoline—"crawling" cutaneous sensation, chilliness with resultant gooseflesh or feeling of warmth—indicate attainment of effective dosage level; occasionally tachycardia, tingling, nausea and epigastric distress, slight hypotensive effect or slight rise in blood pressure may be experienced.

AGE 75. Arteriosclerotic ulceration with erysipeloid reaction and marked inflammation; after administration of oral Priscoline, 25 mg. three times daily, for one week—increased thereafter to 50 mg. four times daily—there is steady improvement, healing in eight weeks. No other medication used.



Priscoline®

FOR COMPLETE INFORMATION on Priscoline ask your CIBA representative or write Medical Service Division, CIBA Pharmaceutical Products, Inc., Summit, N. J. **SUPPLIED:** Priscoline hydrochloride (tolazoline hydrochloride CIBA) is available as 25-mg. tablets (scored), bottles of 100 and 1000; elixir, 25 mg. per 4 ml., in pints; 10-ml. multiple-dose vials, 25 mg. per ml.

Photographs and accompanying clinical data by courtesy of R. I. Lowenberg, M.D., Consultant in Vascular Surgery, Connecticut State Hospital, Middletown, Connecticut.

AGE 68. Arteriosclerosis obliterans cellulitis; sluggish response to saline dressings and procaine penicillin 300,000 units daily; healing speeded by oral Priscoline, 25 mg. four times daily for one week, 25 mg. every three hours thereafter; healing within six weeks.





restlessness and irritability with pain

*one of the 44 uses
for short-acting*

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"OF the various drugs used, codein and NEMBUTAL (*Pentobarbital*, Abbott) were found to be highly effective. It was found that these drugs could be repeated to provide continued restfulness and that fractions of the original doses were often effective as maintenance doses.

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"They usually produce rest and the sleep brought about by their use approximates normal sleep. The action of these drugs is rapid; and if the patient is not disturbed, the sleep may continue from one to five hours."¹

Abbott

1. Gurdjian, E. S., and Webster, J. E., *Amer. J. of Surgery*, 63:236, 1944.

What is the status of_____?

Many times you have asked yourself, "Is the indicated drug
Penicillin . . . Chloramphenicol . . . Aureomycin . . .
Sulfadiazine . . . a combination . . . or what?"

This same problem may confront you many times . . . not only
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Information about new drugs—clinically proved indications . . .
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can be most effective in your daily practice.

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the Councils' functions to you.



SOCIETIES

NINTH DISTRICT MEDICAL SOCIETY met in Jasper in April. The following officers were elected: Alex B. Russell, Winder, president; Bob Jones, Canton, president-elect; and George T. Nicholson, Cornelia, secretary. The physicians participating in the scientific program were Grady N. Coker, Canton; Charles Andrews, Canton; Calvin Sandison, Atlanta; and Robert Whitaker, Jr., Atlanta. Guests at this meeting were David Henry Poer, Atlanta, and Hartwell Joiner, Gainesville. The closing address was delivered by Peter B. Wright,

Augusta. The next meeting will be the third Wednesday in September in Winder.

LAURENS COUNTY MEDICAL SOCIETY met recently at the Country Club in Dublin. Frederick Cheney, of the VA Hospital, was guest speaker at this dinner meeting. Mark Watkins, president, conducted the meeting and was assisted by W. P. Roche, Jr., secretary. R. T. Anderson, chairman of the public relations committee was in charge of the program.

WARE COUNTY MEDICAL SOCIETY met recently in Kingsland at the home of Dr. and Mrs. R. Roy McCollum, two who are noted for their hospitality. The Kingsland meeting is an annual affair and the festivities this year included a barbecue dinner.

DEATHS

CABANISS, William Harvey, 68, Athens, died at a hospital in Leesburg, Florida, April 13, 1954, following a heart attack. Dr. Cabaniss was in Florida on a fishing trip with friends at the time. Burial was in Maxeys, Ga., with the members of the Clarke County Medical Society and Henry Reid, W. W. Brown, R. C. Wilson, Milton P. Jarnagin, and H. D. Allen serving as honorary pall-bearers. A native of Newberry, S. C., Dr. Cabaniss received his Bachelor of Science degree from Newberry College and his M.D. degree from the University of Virginia Medical School. He began his practice in Athens in 1913, where he was a member of the First Baptist Church, serving for many years as a member of the Board of Deacons. He was a member of various civic organizations but his chief interest, beyond his profession, was the breeding of registered Jersey cattle. He was a former director of the American Jersey Cattle Club and a former president of the Georgia Cattle Club.

CRAWFORD, James Harden, 75, Atlanta, died April 11, 1954, in Atlanta after an illness of three months. Born in Oak Mountain Springs, Georgia, he was the son of the late James Madison Crawford, a pioneer Atlanta physician. Dr. Crawford attended Alabama Polytechnic Institute and graduated from the Atlanta College of Physicians and Surgeons. He entered practice in Atlanta 55

years ago and was in active practice until his death. Dr. Crawford was a member of the First Presbyterian Church of Marietta and was on the staff of the Georgia Baptist Hospital and St. Joseph's Infirmary in Atlanta.

HARRIS, Vaude Lee, Warwick, died May 15, 1954, in the Phoebe Putney Hospital, Albany. He was a native of Butts County and a graduate of the Atlanta Medical College. Dr. Harris practiced in Pinehurst and Rochelle before coming to Warwick. He was a member of the Masons, Knights Templar, Shrine and the Warwick Baptist Church. Funeral services for Dr. Harris were held at the Warwick Baptist Church with burial in the Pinehurst Cemetery.

HOWELL, Sam M., 64, Cartersville, died April 13, 1954, after a long illness. Burial was in Oak Hill cemetery; among the pall-bearers were William Dillard, W. Earl Wofford, Ross Whatley, Harold Choate, Harry Bradford. Dr. Howell was a graduate of Mercer University and Atlanta Medical College and, after service in the Army during World War I, opened his practice in Cartersville. To better serve his patients, Dr. Howell, in association with his son Harvey Howell and his son-in-law William B. Quillian, and others, established the Howell-Quillian Clinic. Dr. Howell was a member of the First Baptist Church of Cartersville and a charter member of the Cartersville Rotary Club.

REED, Clinton, 61, Smyrna, died April 26, 1954 in Atlanta after a short illness. Burial in Westview Cemetery followed the funeral at Spring

Hill in Atlanta. Dr. Reed was born in Early County and had been practicing in Atlanta since 1911. He was a graduate of Emory University School of Medicine. He was a member of the Smyrna Baptist Church, Yaarab Temple of the Shrine, and Magnolia Masonic Lodge of Blakely. Dr. Reed is survived by one daughter, Mrs. Smiley M. Bush, Smyrna.

THOMAS, SAMUEL D., of Carrollton, succumbed on April 12, 1954, to a heart attack. Dr. Thomas

PERSONALS

LOUIS BERGER, Atlanta, announces the removal of his offices from 662 West Peachtree St., N.W. to Suite 102, 950 West Peachtree St., N.W. with practice limited to ophthalmology.

L. MINOR BLACKFORD, Atlanta, was honored recently at a tea in Rich's Book Shop. He is the author of "Mine Eyes Have Seen the Glory," the story of the anti-slavery Blackford family who fought for the Confederacy. Material for the book is from the diary of his grandmother, Mary Berkeley Minor Blackford.

CHARLES T. BROWN, JR., Guyton, was honor guest at the reception held on May 27 in Guyton in celebration of his birthday and wedding anniversary. He is not a native son nor was he, according to the citizens of Guyton, being feted because of his long years of service. It is for the outstanding service, his religious fervor, civic pride and many accomplishments that he was thus honored.

H. EUGENE BROWN, Atlanta, was recently appointed instructor in medicine by Dr. Goodrich C. White, President of Emory University. A native of Jackson, Georgia, he has taught zoology at the University of Georgia and more recently has practiced medicine in Atlanta. Dr. White also announced the addition to the faculty, on a voluntary basis, of SIDNEY OLANSKY, Atlanta, and the promotion from instructor to associate of SAMUEL R. POLIAKOFF, and JAMES V. ROGERS, JR. from associate to assistant professor.

ALLEN H. BUNCE, Atlanta, President of the U. S. Pharmacopeial Convention, addressed the 79th Annual Convention of the Georgia Pharmaceutical Association in Atlanta. In his talk, Dr.

started his practice in Carrollton in 1918 and had been Carrollton's only Negro physician since that time. He was a member of the staff of Tanner Memorial Hospital and a deacon of the Mt. Zion Baptist Church. He also took an active part in Scout activities in Carrollton. On his death a resolution expressing "their grievous loss of a significant individual and an ethical member of their professional group" was passed by the Tanner Memorial Hospital staff.

Bunce stressed the importance of letting the people know all the facts about medical care.

PHINIZY CALHOUN, Atlanta, spoke at the recent meeting of the Atlanta Eye, Ear and Throat Society on the "Treatment of Ptoxis with Jaw Winking." JAMES T. FLYNN addressed the group on "Cancer of the Larynx, A Review of the Symposium as Given at the 1953 Academy Meeting."

ENOCH CALLAWAY, LaGrange, is chairman of the Professional Education Committee of the American Cancer Society's Georgia division which, with the Cancer Control Service, sponsored the "Cancer Teaching Day" recently at the Medical College of Georgia. Speakers on the program besides Dr. Callaway were R. B. GREENBLATT, STEPHEN W. BROWN, LOUIS O. J. MANGANIELLO, POMEROY NICHOLS, JR., D. F. MULLINS, R. C. MAJOR, J. R. RINKER and CURTIS CARTER, all of Augusta. HOKE WAMMOCK also of Augusta was Program Chairman.

Mrs. Marie Frances Whitlock Collins, wife of J. C. COLLINS, Collins, died at her home April 30, 1954, after a brief illness.

LEILA DENMARK, Atlanta's Woman of the Year for 1953, was named to the board of directors of the 1954 Woman of the Year organization. Dr. Denmark described the Annual Woman of the Year selection here as "one of the nicest things that ever happened in Atlanta," she added that the WOTY organization should become even more meaningful in the future.

JOHN T. DUPREE, Macon, has been released by the Navy and has resumed his practice in Macon.

HAROLD W. GOLDIN, Rockmart, was elected Chief of Staff of the Rockmart-Aragon Hospital at a recent meeting of the staff. He succeeds J. E. GRIFFIN who resigned on moving to Atlanta. At the same meeting R. B. GOLDIN was named secretary of the staff.

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JAY GOLDSTEIN and LEON GOODMAN, Warner Robins, will occupy a new clinic under construction in Warner Robins as soon as it reaches completion. This building, the Medical Center Clinic on Watson Avenue, will house a suite of offices, bed space and delivery and operating facilities.

WILLIAM S. HELTON, Sandersville, attended the Southern Surgical Convention in Richmond, Virginia, in April. While there he was the guest of his sister, Mrs. George Fultz.

M. KUSNITZ, Alamo, and EDGAR HUNT, Mt. Vernon, spoke recently to the Glenwood PTA. Dr. Kusnitz's subject was "Cancer" and Dr. Hunt addressed the group on "Mental Health."

CHARLES K. RICHARDS and BILL PURCELL, Calhoun, have announced that Gordon Jackson will become associated with them in the practice of medicine in July. Dr. Jackson is a native of Harrison, a graduate of the University of Georgia and the Medical College of Georgia. For the past two years, Dr. Jackson has been undergoing specialized training in obstetrics and surgery.

ARTHUR M. KNIGHT, JR., Waycross, has started a series of lectures on Psychiatry to the nurses and assistants of the Ware County Hospital. Dr. Knight previously conducted a six weeks course on the Nutritional Needs of Body for Maintenance of Good Health.

H. B. JENKINS, Donalsonville, accompanied by his wife and son, sailed recently for Europe on the Surgeons Tour; Dr. Jenkins will attend the International College of Surgeons meeting in England and then the party will spend two months touring the continent.

C. S. JERNIGAN, Sparta, was painfully cut about the face and bruised when he lost control of his car and drove into a ditch on the Milledgeville highway near Sparta recently. Dr. Jernigan was able to return to his home from the hospital after a week and resumed his practice shortly thereafter.

HENRY JENNINGS, Gainesville, was recently elected a vice-president of the Emory University Alumni Association.

VIRGINIA HAMILTON MALEY, Gainesville, spoke recently at the meeting of the DAR in Gainesville on the subject "Perpetuating the Spirit of America through the Conservation of America's Health." Dr. Maley traced the growth of the governmental health program in the state of Georgia.

Dr. and Mrs. WILEY MONROE FLANAGIN, Waycross, celebrated their 50th Wedding Anniversary with a reception at their home in Waycross. From an azalea decked garden guests entered the living room where Mrs. Luther H. Grovenstein, daughter of the Flanagin's, presented the callers to her parents. Also receiving with their parents were Dr. and Mrs. STEWART FLANAGIN, Augusta. Several hundred guests called between the hours of five and seven to extend congratulations to Dr. and Mrs. Flanagin on their Golden Wedding Anniversary.



Wiley M. Flanagin, M.D.

R. BRUCE LOGUE, Atlanta, has been re-elected to a three year term as a member of the Board of Directors of the American Heart Association to represent the Georgia Heart Association. CARTER SMITH, Atlanta, will continue to serve as Secretary of the Section on Clinical Cardiology of the American Heart Association and WILLIAM F. HAMILTON, SR., Augusta, was re-elected to a one year term as member of the Board of Directors to represent the section on Basic Science.

WILLIAM H. MATHIS, JR., Marietta, has been consulting radiologist at the Gordon County Hospital. Dr. Mathis is chief of the department of radiology at Kennestone Hospital in Marietta. HARRY E. DAWSON, Shannon, has been added to the general and surgical staff of the Gordon County Hospital.

SPENCE MCCLELLAND, Atlanta, has recently returned from a tour of Navy duty to resume his practice in Atlanta.

ARTHUR MERRILL, Atlanta, spoke at the 74th Annual Meeting of the Louisiana State Medical Society held in New Orleans, May 20-22. His subject was "Acute Renal Failure."

RALPH A. MONACO, Columbus, was recently elected president of the Georgia Association of Pathologists. Other officers of the association

are WARREN B. MATTHEWS, Atlanta, vice-president, and DARRELL AYER, Atlanta, secretary-treasurer.

MICHAEL V. MURPHY, Atlanta, announces his release from active duty with the U. S. Navy and his return to the practice of Internal Medicine with offices at 21 Eighth Street, N.E.

DEARING A. NASH, Savannah, has announced the opening of his office at 3½ East Gordon Street for the general practice of medicine. Dr. Nash is a graduate of the Medical College of Georgia and has recently been discharged from the U. S. Army.

In the recent reorganization of the Blackshear Clinic two new physicians were added to the staff. They are A. P. OHLMACHER and WILLIAM F. AUSTIN, formerly in practice in Woodbine. Dr. Ohlmacher specializes in surgery and Dr. Austin will assist in surgery and do general practice.

W. L. OSTEEN, Savannah, spoke at a recent meeting of the Savannah Junior Chamber of Commerce on "The Background of the Blood Program."

T. L. PARKER, Douglas, announces the removal of his offices from the Doctors Building to the new Douglas-Coffee County Hospital.

J. C. PATTERSON, Cuthbert, and Mrs. Patterson are in Europe on a two month tour which will include seven countries. The group will attend the meeting of the International College of Surgeons in London and medical meetings in Paris.

C. E. PATTILLO, Decatur, was host at dinner recently to four classmates of the class of 1910 at Emory Medical School. They are C. C. AVEN, Atlanta; W. C. THOMPSON, Anderson, S. C.; C. W. HARVEY, Hogansville; and L. R. MILLER, Graceville, Fla.

ROBERT C. PENDERGRASS, Americus, spoke at the kickoff dinner for the fund raising drive of the Randolph County unit of the American Cancer Society. Dr. Pendergrass said "one out of every six persons now living in the United States will probably develop cancer at some time in their lives," and went on to emphasize the fearful toll exacted by cancer due to ignorance, prejudice, fear and delay in seeking treatment.

FINCHER C. POWELL, Decatur, has resumed his practice after an absence of 18 months in the U.

S. Navy. He is sharing offices with W. PAT SMITH at 319 Church Street.

CECIL REID REINSTEIN, Atlanta, has resigned his position with the Communicable Disease Center, U. S. Public Health Service, Atlanta, to accept a position as Medical Director of the South-central Health District, with headquarters at Twin Falls, Idaho.

WALTER J. REVELL, Louisville, has recently moved into the new Revell Clinic on Seventh Street, Louisville.

CHARLES H. RICHARDSON, SR., Macon, spoke at a recent meeting of the Macon Kiwanis Club on the Art of Growing Old. Dr. Richardson said 51 per cent of deaths today are caused by heart disease with cancer as the number two killer.

CHARLES RIESER, Atlanta, was elected treasurer of the Southeastern section, American Urological Association at its annual convention in Palm Beach, Fla.

M. HINES ROBERTS, Atlanta, clinical professor of pediatrics at Emory University and medical director at Eggleston Hospital for Children addressed the Richmond Pediatric Society on May 18th.

ALBERT ROSENBERG, Atlanta, has been made a Fellow of the American Academy of Pediatrics.

T. F. SELLERS, Atlanta, Director of the Georgia Department of Public Health was elected second vice-president of the newly organized American College of Preventive Medicine.

JOHN L. STAPLETON, Columbus, was elected president of the Georgia Urological Association at a meeting held in Macon in May.

At the 41st Annual Convention of the Georgia Tuberculosis Association JOHN H. VENABLE, Atlanta, spoke on "Training of Physicians" and THOMAS C. LITTLE, Statesboro, addressed the group on the "Training of Nurses."

D. B. WARE, Fitzgerald, recently received a diamond-studded gold pin for his 50 years of service as surgeon for the Atlantic Coast Line Railroad. The pin was presented to Dr. Ware by Mr. E. M. Westbrook of Wilmington, N. C., business manager of the Relief Department of the railroad.

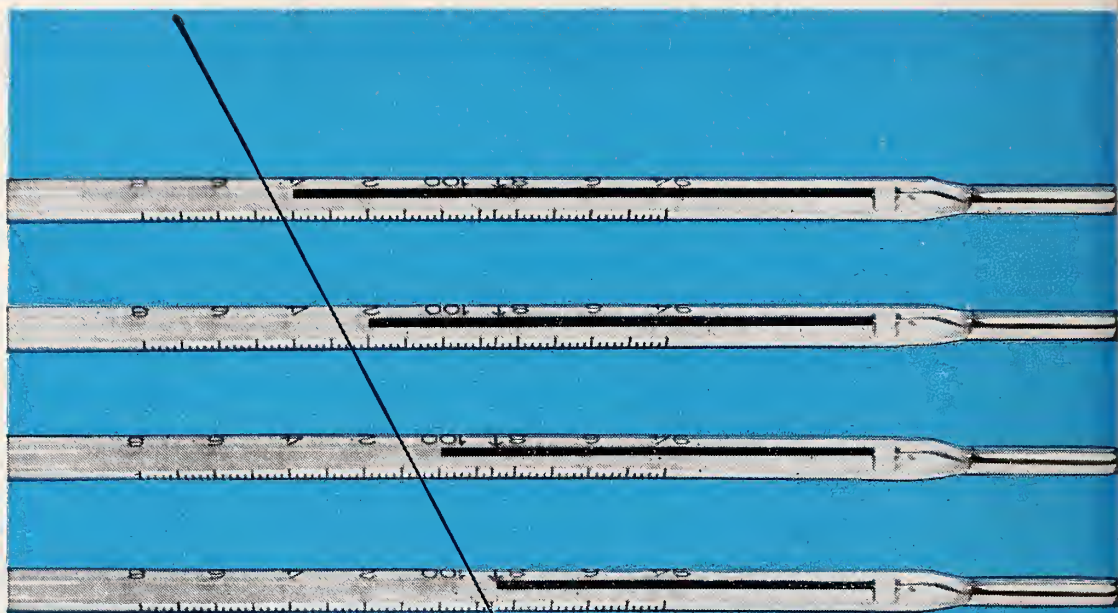
A. J. WARING, Savannah, was elected president of the Poetry Society of Georgia at their annual meeting held in May.

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English, A. R., et al.: Antibiotics Annual (1953-1954),
New York, Medical Encyclopedia, Inc., 1953, p. 70.

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STYLE

Ordinarily articles should not exceed 3,000 words. Only under exceptional circumstances will articles of over 4,000 words be published. Footnotes, bibliographies and legends should be typed on separate sheets, double-spaced. Bibliographies should conform to the style of the Quarterly Cumulative Index published by the American Medical Association—i.e., name of author, title of article, name of periodicals with volume, page, month, day of month if weekly and the year. They should be listed in alphabetical order and numbered in sequence. Example: 1. Jones, S. R.: Spontaneous Epistaxis. Arch. Int. Med., 36:434 (Dec.) 1946.

NEWS NOTES

District and County Medical Societies, Association members and readers are invited to send in any news items of general concern to members of the Medical Association of Georgia.

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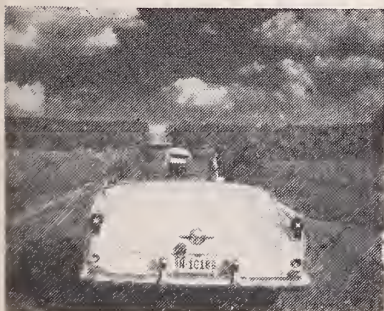
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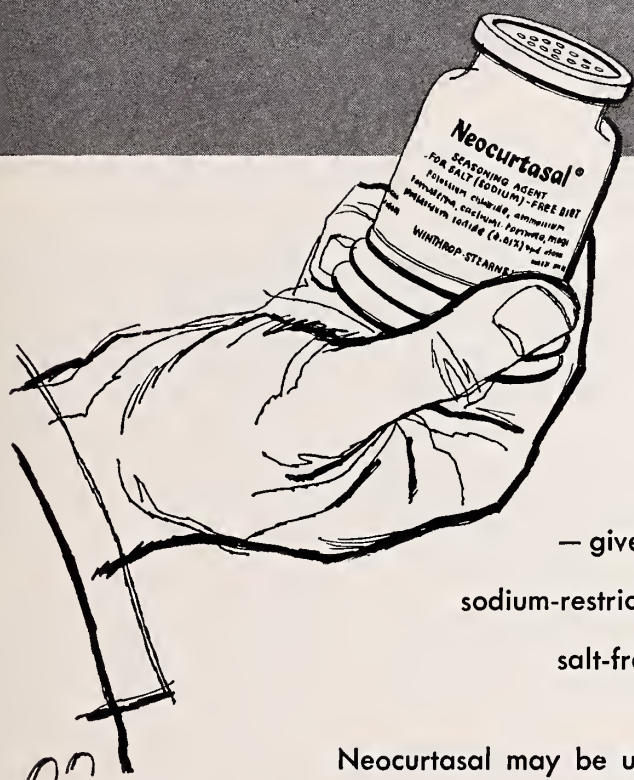
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1. Heller, E. M.: The Treatment of Essential
Hypertension. *Canad. Med. Assn.
Jour.*, 61:293, Sept., 1949.

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A selective alkaloidal extract of hypotensive principles obtained by fractionation from *Veratrum viride*. Representing less than 1% of the whole root, it is freed from the gross of the root substance. It is generically designated alkavervir. In the treatment of hypertension it presents these desirable properties:

1 Biologic assay—based on actual blood pressure reduction in mammals—assures uniform potency and constant pharmacologic action.

2 Blood pressure is lowered by centrally mediated action; there is no ganglionic or adrenergic blocking.

3 Therapy is rarely, if ever, fraught with the danger of postural hypotension.

4 Hypotensive action is independent of alterations in heart rate.

5 Cardiac output is not reduced.

6 Renal function, unless previously grossly reduced, is not compromised.

7 Cerebral blood flow is not decreased.

8 Cardiac work is not increased, tachycardia is not engendered.

9 No dangerous toxic effects from oral administration, no deaths attributable to Veriloid have been reported. Side actions of sialorrhea, substernal burning, bradycardia, nausea, and vomiting (due to over dosage) are readily over-

come and thereafter avoided by dosage adjustment.

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11 Tolerance or idiosyncrasy rarely develops; allergic reactions have not been encountered. Hence tablets Veriloid can be given for the long treatment needed in severe hypertension.

12 Continuing therapy with Veriloid has not led to interference with appetite or with excretory function.

13 Because of its rapidly induced, prolonged action (6 to 8 hours), tablets Veriloid provide around the clock hypotensive effect from 4 doses daily, make today's dosage effective today, and usually prevent hypertensive "spiking" during the night.

14 A notable safety factor in intravenous administration: *extent to which blood pressure is lowered is directly within the physician's control.*

Tablets Veriloid

The slow-dissolving, scored tablets, supplied in 2 mg. and 3 mg. potencies, moderate to severe hypertension they produce gratifying response in many patients. According to published reports¹ this response can be maintained for long periods in fully 30% of patients; combination with other hypotensive agents has been credited with greatly increasing this percentage.² Initial daily dosage 9 mg., given in divided doses, not less than 4 hours apart, preferably after meals. To be increased gradually, by small increments, till maximum tolerated dose is reached. Maintenance dose 9 to 24 mg. daily.

Solution Intravenous

For immediate reduction of critically elevated blood pressure in hypertensive emergencies such as hypertensive state accompanying cerebral vascular disease, hypertensive crisis (encephalopathy), toxemias of pregnancy. It lowers the blood pressure promptly, to any degree the physician desires, and with notable safety. Excessive hypotensive and bradycardic effects should be invoked they are readily overcome by simple means. Supplied in boxes of six 5 cc. ampuls. The solution contains 0.4 mg. of Veriloid per cc.

Solution Intramuscular

For maintenance of blood pressure in such critical instances, and for primary use in less critical situations which do not show the same immediate urgency. Provides 2 mg. of Veriloid per cc. in isotonic aqueous solution incorporating one per cent procaine hydrochloride. A single dose lowers the blood pressure significantly, reaches its maximum hypotensive effect in 60 to 90 minutes. By repeated injections (every 3 to 6 hours) blood pressure may be kept depressed for hours or days if necessary. Supplied in boxes of six 2 cc. ampuls. Complete instructions as to dosage and administration accompany every ampul. The parenteral preparations of Veriloid should be noted carefully.

1. Kauntze, R., and Trounce, J.: Treatment of Arterial Hypertension with Veriloid (*Veratrum Viride*), *Lancet* 2:1002 (Dec. 1) 1951.
2. Wilkins, R. W.: Combination of Drugs in the Treatment of Essential Hypertension, *Mississippi Doctor* 30:359 (Apr.) 1953.
3. Stearns, N. S. and Ellis, L. B.: Acute Effects of

Intravenous Administration of a Preparation of *Veratrum Viride* in Patients with Severe Forms of Hypertensive Disease, *New England J. Med.* 246:397 (Mar. 13) 1952.

4. Moyer, J. H., and Johnson, I.: Intramuscular Veriloid (Aqueous Solution) As a Hypotensive Agent, *Am. J. M. Sc.* 226:477 (Nov.) 1953.

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president's page

Now that the election of officers is over, I want to urge all of our members to forget their past differences and pull together for the general welfare and advancement of the Medical Association of Georgia.

Constructive criticism is good for all organizations, including our own, and helps the organization to advance and progress. On the other hand, destructive criticism, which arises from personal feeling and personal animosities, is always bad and should never be welcomed. Destructive criticism causes unnecessary division among the members. As a result of that division the whole organization is weakened and is less able to carry out the MAG program.

This is especially true at the present time when the whole medical profession is receiving unjustified criticism from many sources outside of the profession. Our welfare, the welfare of our profession and its continued progress as an independent and democratic profession not under the control and dictatorship of government, largely depends upon our mutual forbearance in our dealings with each other, our mutual efforts to assist one another in the profession and our working to safeguard it from unjustified outside criticism. If we ourselves indulge in unjustified criticism of our fellow members, I do not see how that can but encourage others to pick up and carry on the same unjustified criticism of the profession as a whole. I sincerely hope that we will forget our personal differences and our personal feelings and work together as one body and one organization for the general welfare and advancement of the Association.

I hope that you will not merely read this and then forget about it, but that you will take it to heart and keep it there when the election of officers comes up next year.

hospital page



UPSON COUNTY HOSPITAL Thomaston, Georgia

The Upson County Hospital at Thomaston, Georgia, was opened in April, 1951. With the opening of the 92 bed hospital, three clinics or smaller hospitals in the community closed.

CHATTOOGA COUNTY HOSPITAL Summerville, Georgia

The Chattooga County Hospital at Summerville, Georgia, was opened for the reception of patients in January, 1952. The hospital has 31 beds.



Increased Hill Burton Appropriation

President Eisenhower will recommend that Congress increase these three health program appropriations for fiscal 1955: Hill-Burton hospital construction from \$50 million to \$75 million; vocational education from \$17.5 to \$18.6 million; and Public Health Service grants (tuberculosis, venereal disease, etc.) from \$19.4 million to \$22.8 million. Announcement that the administration would not insist on holding to the Budget Bureau's figures was made by Senator Thye before a session of the appropriations subcommittee of which he is chairman.

The new figure for Hill-Burton would be \$10 million higher than the current appropriation,

but the other two changes would in effect bring the programs up to the current level of spending. The Hill-Burton appropriation would be applied only to grants for hospitals; legislation passed by the House and pending in the Senate Health Subcommittee to extend the Hill-Burton program would require additional appropriations. The administration made no mention of increasing the funds for vocational rehabilitation, inasmuch as legislation to expand this program is pending in House and Senate. If the legislation is adopted, vocational rehabilitation appropriations would be increased from \$19.5 million to \$23 million or more.

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ACHROMYCIN has demonstrated notable effectiveness in a wide variety of clinical applications and the following characteristics are outstanding:

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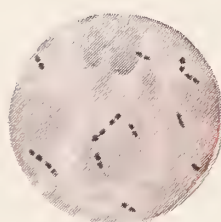
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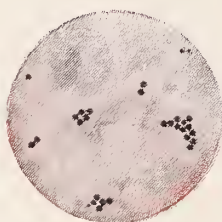
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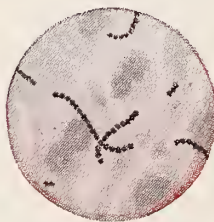
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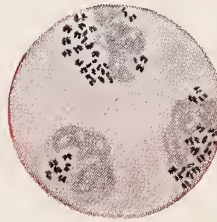
Pneumococci



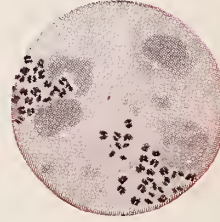
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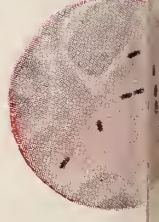
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CAPSULES: 250 mg., 100 mg., 50 mg.

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A three months full time course covering general and regional anesthesia, with special demonstrations in the clinics and on the cadaver of caudal, spinal, field blocks, etc.; instruction in intravenous anesthesia, oxygen therapy resuscitation, aspiration bronchoscopy; attendance at departmental and general conferences.

For Information about these and other courses Address
THE DEAN, 345 West 50th Street, New York 19, N. Y.



Management of the Cardiac in Industry

DURING the past ten years there has been a marked increase in the number of industries in communities throughout the state. Many physicians have been called upon to perform pre-employment physical examinations and to advise on policies of hiring and retiring individuals with cardiac and other handicaps. The family physician is frequently confronted with the decision of returning cardiacs to work. It thus behooves every doctor to keep abreast of our knowledge of work capabilities of cardiacs.

The physician should take every opportunity to educate the managers and personnel directors of industrial plants in order to remove prejudice toward cardiacs resulting from publicity given to deaths from "heart attacks." The doctor should acquaint these officials with certain well-substantiated facts: that people with heart disease often produce better than unimpaired workers; that many cardiac patients under good medical management live 20 to 30 years after diagnosis; and that the heart patient, if placed at a job for which he is physically qualified, runs no special risk and does not raise compensation insurance rates. The worker with unknown or unsuspected heart disease is a much greater risk to the employer.

Then, if possible, the examining physician should make a tour through the plant to get an idea of the physical layout and the requirements of the various jobs.

To make an intelligent recommendation concerning a cardiac, the physician should accustom himself to think in terms of the etiology of the disease (whether rheumatic, congenital, hypertensive or arteriosclerotic) as well as the anatomic abnormalities (valvular damage, cardiac hypertrophy, etc.) and the physiological abnormalities

(arrhythmia, angina, etc.). Then he should determine through interview just how much effort will cause symptoms. It is often profitable for the doctor to give a test of exertion by accompanying the patient up a flight of steps, or on a walk around the block to more accurately judge the presenting symptoms.

With this information he can then make the proper functional and therapeutic classification of the individual's work capacity. The Heart Association classification table was published on the Heart Page of the April issue of the *Journal of the M.A.G.*

Cardiacs grouped in the most favorable classification (1-A) can invariably be given unlimited activity. General health advice should be given these patients. For example, those with hypertension should be warned against working in high places and rheumatic heart patients should be told to avoid jobs where exposure to cold or damp conditions is probable, or where risk of respiratory infections is greater than usual.

Those patients in less favorable classification groups should take jobs according to the degree of incapacity. Many will be able to work 40 hours a week in clerical and sales jobs and in most skilled and semi-skilled occupations. Those with considerable disease can be employed in sedentary or part time jobs. A trial of work is often helpful in evaluating capacity where doubt exists as to the degree of functional disability.

The physician must remember that emotional maladjustment and the amount of cardiac anxiety that is present influence the symptomatology and the cardiac capacity. A person with marked emotional instability superimposed on organic heart disease frequently exhibits symptoms out of proportion to the structural lesion. It is important

that the doctor recognize these factors in evaluating lowered work tolerance. Reassurance, explanation of the part played by anxiety in the causation of symptoms, and the type of psychotherapy which an understanding family doctor can give will frequently alleviate symptoms and be the first step toward getting the cardiac back to work.

It has been shown that a large proportion of patients with rheumatic, congenital, hypertensive and arteriosclerotic heart disease can work successfully. Follow-up studies on selectively placed cardiacs in industry fail to show that continued

employment has any adverse effects on the heart disease when medical supervision is provided. Many individuals with a history of myocardial infarction, for example, are able to resume work and continue in gainful employment for relatively long periods without increased danger of further attacks.

The Georgia Heart Association has a number of pamphlets to help the physician with the handling of cardiacs in industry and the State Vocational Rehabilitation Office stands ready to assist in individual problems.

The Better Health Council

At the annual business meeting of the Better Health Council of Georgia, June 1, 1954, at the Academy of Medicine, Atlanta, the following officers were elected: Mrs. Bruce Schaefer, Toccoa, Ga., President; Tully T. Blalock, Atlanta, President-elect; Mrs. Edgar Dunstan, Atlanta, Secretary; Mr. Robert F. Whitaker, Emory University, was re-elected Treasurer.

Elected to the Board of Directors were Mr. Frank Smith, Clayton, President of the Georgia Association for Mental Health; Col. E. D. Kenyon, Gainesville; Mr. John Baum, Milledgeville; Mr. Winston Garth, Gainesville, Mr. Howard Callaway, Hamilton, Ga., and Mrs. Alden Eddy, honorary member.

Mrs. Schaefer announced her appointments of chairmen for the following committees: Nominating—Mrs. Alden Eddy; Membership—T. F. Sellers and Mrs. Shelley Davis, co-chairmen; Finance—Tully T. Blalock; Program—Hugh Wood.

Mrs. Shelley Davis reported on the progress of the Council and named, among other achievements for the year, the sponsoring of four regional health conferences which gave the Council the opportunity to contact approximately 6,500 citizens in 113 counties in the state. Also, 75 per cent of those attending the health conferences were from lay groups.

Through these regional health meetings the volunteer and official health organizations have an opportunity to distribute their pamphlets and pre-

sent information on services which are available from their organizations to the people in Georgia. Interest has been stimulated at these meetings and as a result several Health Councils were organized during the year. A continuous cycle of regional health conferences is one of the paramount future projects of the Council.

Rufus Payne, Superintendent of the Eugene Talmadge Memorial Hospital in Augusta, opened the annual meeting by expressing the hope that programs of training, medical care and research at the hospital may help solve Georgia's health problems and that the hospital's program will be aimed toward the development of Georgia's human and material resources. The hospital will serve local communities in Georgia in two ways, Dr. Payne said:

1. It will supplement local medical facilities by giving physicians the opportunity to refer patients to the hospital if local facilities for diagnosis and treatment do not meet the needs.

2. The hospital will help local hospitals solve financial problems by caring for some indigent patients when local communities have exhausted their resources. Such patients must be referred to the hospital by local physicians.

A more complete research program will be developed, and approved internships for technical help such as medical social workers, dietitians, physical therapists and medical record librarians will eventually be offered.

The Geriatric Diet strikes a happy balance!



Your elderly patient may narrow down his food range to the point where foods high in protein, vitamins, and minerals are virtually eliminated. These ideas may help you show him how to enjoy a better-balanced diet.

These are essential—

Meat is as important now as ever. Fish steaks, chicken parts, chops, or cutlets can be bought in small portions. And adding skim milk powder to hamburger boosts both protein and calcium.

Plenty of fruits and vegetables mean adequate vitamins in proper balance. Chopped or strained vegetables and canned fruits are easy to chew. Salads need no cooking—but a sprig of parsley isn't enough.

Be sure the fluid intake is liberal. And remind your patient that it need not necessarily be water.

These are for fun—

Good company and a pretty plate make a happy combination. But if your patient eats alone, a tray in a sunny window makes all outdoors the guest.

A one-dish casserole gives free rein to the imagination and cuts down dishwashing. But perk up flavor with spices and herbs.

Beverages of moderate alcoholic content before dinner and at bedtime often aid appetite and may induce a better night's sleep.

The number of people over 60 is still on the upswing. And with proper attention to diet, these added years can be made more profitable and happy both for the elderly and their families.

United States Brewers Foundation

Beer—America's Beverage of Moderation

Sodium 17 mg, Calories 104/8 oz. glass

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Meat...

and the Dietary Treatment of Gastrointestinal Disorders

A recent study points out that patients with peptic ulcer, ulcerative colitis or regional enteritis can effectively utilize good quality protein from animal sources.* Protein hydrolysates apparently are less effectively utilized than intact protein.

In patients with uncomplicated peptic ulcer on regimens providing intact animal proteins the patterns of amino acid excretion in urine and feces were similar to those in normal subjects. In patients with ulcerative colitis or regional enteritis the increased output of nitrogen and amino acids in the feces was attributed to loss of intestinal secretions, inflammatory exudate, and blood. Although the patients utilized intact animal proteins effectively, the authors suggested that an intake of more than one gram of dietary protein per kilogram of body weight might be useful.

On the basis of this study a dietary plan recommended for treatment of gastrointestinal disorders provides at least one gram, of protein per kilogram of body weight, but preferably more. Meat constitutes one of the important sources of animal protein in the plan.

In dietotherapy, meat serves many important physiologic and nutritional functions. Its appetizing flavor animates the desire to eat and promotes good digestion. Meat is easily and almost completely digested. Its high content of protein provides goodly amounts of all the essential amino acids well supplemented with others. Meat also contributes valuable amounts of many B vitamins and of essential minerals, especially iron, phosphorus, and potassium.

*Kirsner, J. B.; Brandt, M. B., and Sheffner, A. L.: Diet and Amino Acid Utilization in Gastrointestinal Disorders, *J. Am. Dietet. A.* 29:1103 (Nov.) 1953.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.



A m e r i c a n M e a t I n s t i t u t e
Main Office, Chicago... Members Throughout the United States

the executive secretary's letter

The Date Is Set

MAG Scientific Work Committee has set the date for the 105th Annual Session of the Medical Association of Georgia. Mark your calendar for *May 1-4, 1955, Bon Air Hotel, Augusta, Georgia*. Plans for this meeting are well along and the Richmond County Medical Society promises a successful show for all concerned.

P. S. R. A.

Spelled out, it stands for the Professional Service Representatives Association whose members are known to the physician as detail men. This organization has gone all-out in support of your Association. For instance through the detail man's support, the Association's 1954 Macon Annual Session was a financial success. And it might be well to remember that the *JMAG* receives this same type of support upon the recommendation of the detail man. Certainly the Association can express its appreciation by having Association members show the detail man the courtesy of their office.

The Short Form

Within the next few months all MAG members will receive a *short* questionnaire from the Headquarters Office requesting data on the physician's background (the usual vital statistics; age, schooling, etc.). This material will be put in a confidential file to assist in keeping accurate membership records. The records and files of the Association are in the process of being reorganized and this information is necessary. Please fill out and return this questionnaire promptly.

Life Members

For clarification, the status of MAG Life Membership is presently being studied by a special committee of Council. The MAG Constitution and By-Laws are rather vague in that they only stipulate that upon being elected to Life Membership said member is exempt from MAG dues. Nothing is said about rights and privileges of membership. MAG Council has ruled *temporarily* that based on precedent, all MAG Life Members will receive copies of the *JMAG* free, receive the benefits of Medical Defense and have the right to hold office and vote in the Association.

General Practitioners

Georgia Academy of General Practice will hold its Sixth Annual Session at the Biltmore Hotel,

Atlanta, October 20-21, 1954. Fourteen guest speakers will present papers during the two day program. GAGP members are currently conducting a campaign for increased Georgia membership—and a monthly bulletin, the *Georgia General Practitioner*, has been successfully launched by this group. All non-member GP physicians are invited to write this office for membership and GAGP Annual Session information.

MAG Delinquents

Some *former* MAG members now are in the delinquent category because their dues were not received by April 1. Delinquent members do not have the right to vote or hold office nor are they covered by the Medical Defense privileges. The Constitution and By-Laws clearly states "Any member whose name has not been reported and whose dues for the current year have not been remitted to the Secretary-Treasurer on or before April 1st, shall stand suspended until his name is properly reported and his dues for the current year properly remitted." If the shoe fits—see your County Medical Society Secretary and remit promptly.

Sesquicentennial

The Georgia Medical Society, Savannah, Georgia, will celebrate 150 years of proud history on the occasion of their Sesquicentennial scheduled for two days early in October. This County Medical Society is the second oldest in the United States, having been founded in 1804. The Association and its 80 component county medical societies salute the Georgia Medical Society, "granddaddy" of them all. Look for the details of this event in an early issue of the *Journal*.

Vacation Time

With the cover picture setting a vacation theme, it's timely to comment on the lure of the open road. It may be just fishin' or it may be an extended road tour of Americana, depending on time allowed away from a busy practice. With the "dog days" of July and August already here, best wishes for a pleasant time away from the hectic life of a daily practice.

Milton D. Krueger
Executive Secretary

the month in washington

Reinsurance

Washington, D. C.—The controversial health reinsurance issue has come back into prominence, and under conditions that make the whole question about as complicated as it can get. The bill would have the Federal Government underwrite voluntary health insurance plans if they agree to experiment with risks not usually covered.

Although this measure is a major part of President Eisenhower's health program, it became bogged down in the House Interstate and Foreign Commerce Committee when widespread opposition developed. Then the Committee Chairman, Rep. Charles E. Wolverton (R.-N. J.), turned to one of his favorite subjects, a plan for federal guarantee of private loans to health facilities for construction and equipment. This bill, however, was not supported by the administration.

Mortgage Guarantee Bill

In an effort to placate the opposition, Mr. Wolverton offered to eliminate a number of objectionable features from the mortgage guarantee bill. At the same time there were reports that he proposed to merge this bill with the administration-supported reinsurance bill. Meanwhile, Henry J. Kaiser made two special trips to Washington to help out his friend, Mr. Wolverton, by putting his weight behind the mortgage loan idea. That was not surprising inasmuch as Mr. Kaiser had helped to draw up the bill, which would greatly benefit health centers such as those started on the West Coast by the Kaiser Foundation.

Mr. Kaiser, saying he was producing a film to promote the mortgage loan plan, went to the unusual extent of making a direct appeal to Washington news correspondents to write favorable copy about the bill.

While these Wolverton-Kaiser maneuverings were taking place on the mortgage bill, it became apparent that President Eisenhower was not ready to abandon the reinsurance idea. He called a number of executives of major life insurance companies to the White House to try to impress them with the merits of reinsurance and in other ways indicated he still wanted to see the bill passed this session. Secretary Hobby, whose original testimony for reinsurance had been restrained, also

joined in the last-minute campaign. But it appeared the tangle might be too complicated even for Mr. Eisenhower to unravel before adjournment.

Hill-Burton Expansion

Most other parts of the Eisenhower health program were moving through Congress, even though some were off schedule. (Of the major bills, AMA opposes only reinsurance.) Legislation to expand the Hill-Burton hospital construction program cleared what might have been a serious obstacle when it was reported out by the Senate committee. Compared with the House bill, the Senate bill gave more discretion to state health authorities in use of funds for constructing facilities for the chronically ill, for nursing homes, and for health centers. However, the Senate would require that funds earmarked for rehabilitation centers be used for the stated purpose. The Senate also would rule out the possibility of U. S. grants to centers devoted solely to treatment. Unless the facility could qualify as a diagnostic center, or a diagnostic-treatment center, it could not be eligible under the Senate bill. This safeguard was not in the House bill.

Doctor Draft Amendment

The doctor draft amendment, to strengthen Defense Department's hand in dealing with physicians who might be security risks, had passed the Senate, been reported by the House committee, and was almost a law. Also about to be enacted was a provision liberalizing medical expense deductions from taxable income. The long-dormant bill to transfer responsibility for Indians' health matters from the Indian Bureau in the Interior Department to Public Health Service in the Department of Health, Education, and Welfare was pointed toward enactment, but might possibly be held up by objections of Senators from a few western states. The Interior Department had dropped its original objection.

**From Washington Office
American Medical Association
1523 L Street, N. W.
Washington 5, D. C.**

Tumors of Bones

PETER B. WRIGHT, M.D., Augusta, Ga.

THE LATE DR. BLOODGOOD stated: "Less and less today are the clinical features of benign and malignant tumors of bones, or of disease of bone, helpful in the diagnosis; but they should never be neglected. In former years when malignant disease could be recognized clinically, there were no cures."

We rely on x-ray, pathology, or both, for the diagnosis of tumors of bones. A detailed history is, as with other disorders, imperative. History of the immediate complaint should be taken, also a careful medical and family past history should be recorded.

Clinical Observations

Frequently pain is the initial complaint and the reason for seeking medical advice. This pain is variable and rarely characteristic. It may be so slight that it will not arouse the suspicion of the physician, or it may be so severe that the patient will need sedatives and narcotics for relief. The pain may be constant or intermittent. There may be mild discomfort until activity exaggerates the symptoms to the point of restricting the movements of the neighboring joints. The size of the tumor does not necessarily reflect the intensity of the pain. Pain may be localized to the tumor area or be referred to distant points. Pain may develop gradually and increase steadily over a period of several weeks or months or it may appear suddenly, with no history of trauma. With malignant tumors the patient's general appearance may be that of a normal individual or of one whose general health is seriously affected. As the lesion develops, a marked anemia may be noted.

Localization of the Tumor

Tumors of bone may occur at any site in the skeleton but it is well to remember that they have certain areas of predilection. Primary neoplasms tend to occur at the extremities of a bone rather than in its shaft. The areas of rapid bone growth, near the epiphyses, are the sites most frequently involved.

Clinical Examination of the Tumor

The tumor may vary from a slight enlargement to an obvious mass. The veins of the skin are usually enlarged and make a bizarre pattern. The skin takes on a peculiar cyanotic, reddish color. This is almost characteristic of sarcoma. The skin may be adherent to the underlying tumor. Adherent reddened skin, associated with fluctuation due to softening of the underlying tumor, may simulate an inflammatory lesion. On palpation of the tumor a "parchment-like" crackling may be elicited. In others the tumor will be found to be hard, firm and rubbery in consistency. The tumor may be irregular or may be quite smooth. In some tumors the thrills and bruits of an aneurism may be present.

Malignant bone tumors usually metastasize by way of the blood stream and most frequently the lungs are the first organs affected. A careful x-ray study of the chest must be made before surgery is performed to excise the tumor. Despite negative chest x-rays and wide-berth excision of the tumor, some patients die within a few months due to extensive pulmonary metastases.

After an accurate history is taken and a detailed physical examination made, laboratory data should be assembled in order to complete the study.

Leucocytosis is high in pyogenic infections and not usually elevated in neoplasms. There may be marked anemia of the secondary type. The urine should be examined completely, since in a case of suspected multiple myeloma, Bence-Jones protein may be found. Bence-Jones protein is not pathognomonic of multiple myeloma but, when other findings indicate the presence of the disease, does assist in making the diagnosis. In primary bone tumors there is noted little or no disturbance of the calcium and phosphorus concentrations of the blood serum. Elevation of the serum alkaline phosphatase is a good indication of activity of a bone tumor even though it gives no unequivocal

indication concerning the nature of the tumor. In bone metastases of cancer of the prostate the serum-acid phosphatase is usually elevated.

Serum inorganic phosphorus, while low in osteomalacia and hyperparathyroidism, is usually high in osteolytic metastatic diseases and plasma cell myeloma. The total serum calcium is high in hyperparathyroidism and normal in most bone tumors. This is a differential point to be remembered.

X-rays of the suspected lesion, the lung fields and, in certain cases, a complete skeletal survey should be made. The most important diagnostic aid is the biopsy. With a pathological consultation in the operating room, including a frozen section if needed, the diagnosis can generally be made within 20 minutes. If the interval between biopsy and definitive treatment is prolonged, the wound should be carefully closed in layers and a snugly-fitting pressure dressing applied. Aspiration biopsy is not too reliable.

Treatment of malignant bone tumors generally involves a mutilating operation, usually amputation. Amputation is employed in an attempt at permanent cure, for palliative means or to rid the patient of a useless cumbersome extremity. Amputation should be performed proximal to the affected bone rather than through it, a good rule being "one joint above the bone involved."

With improved prostheses for hip disarticulation and even hemipelvectomy, surgeons are less concerned with the need of preserving part of the femur.

The Revised Classification of Bone Tumors 1939 is probably the most practical. The following are some of the most frequently encountered tumors of bone.

Benign Tumors

Osteochondromata are benign tumors. They are bony outgrowths having a thin cartilagenous cap and are situated near the ends of long bones. As a rule the patient discovers the tumor because a secondary bursitis overlying the tumor produces mild pain. When the symptoms become acute with secondary signs of pressure or edema, a malignant change should be suspected. Most of these growths do not require surgery but simple surgical removal may be indicated because of size, pressure or pain. Geschichter and Copeland³ in their series of benign exostoses report five per cent of their cases show secondary malignant changes. Wholesale removal of these growths is not indicated nor warranted but a close "follow-

up" is imperative because of the possibility of malignant changes. These growths do not respond to radiation.

Deforming Chondrodysplasia is a distinct clinical entity in which there are multiple tumors in a single patient. There are often numerous other skeletal deformities such as bowing and shortening of the bones, and widening and irregularity of their metaphyseal ends. In this disease the hereditary factor is extremely prominent and has been traced through as many as four or five generations. Prognosis for life in these cases is good although there is no treatment other than operative correction of deformities. Surgery should not be performed until after the growth period. Exostoses causing disturbance by pressure on nerves or blood vessels are exceptions and here excision is indicated regardless of the age of the patient.

Enchondromas are benign, centrally located tumors of cartilagenous derivation. They occur in the small bones of the hands and feet, the ribs, spine, femur, tibia, humerus or pelvis, usually in patients between the ages of 15 and 30. The phalanges of the hand are the most often affected locations. The x-ray reveals an expanded and cystic area within a shell of cortical bone.

Simple Chondromata are usually symptomless and are discovered by the patient because of swelling or deformity. Pathologic fracture may occur before recognition of the condition. Resection or excision is the procedure of choice. Histologically, there are strands of connective tissue and myxomatous material as well as cartilage, and these lesions are apt to recur if incompletely excised. The larger of these tumors should be considered potentially malignant and need to be followed closely.

Benign Giant Cell Tumor is a solitary lesion of cancellous bone occurring near the ends of long bones, particularly in the lower femur, the upper tibia, the lower radius and upper fibula. It is an osteolytic lesion which arises beneath the cortex and gradually expands until only a shell of bone remains. The periosteum usually acts as a limiting membrane. Although characteristically benign, recurrences after surgical removal are not rare. The histories given by these patients reveal the presence of pain, swelling and often fracture. These symptoms exist over a period of two to 14 months. Treatment has been increasingly conservative and now x-ray therapy alone is advocated by some authorities. Curettment and packing with bone

chips is the procedure of choice. In one of our cases recurrence of the tumor and invasion of the soft tissues required amputation. A pathological diagnosis should be established before any type of treatment is instituted.

Osteoid Osteoma, first described by Jaffe in 1932, is now recognized as an entity. Jaffe defines it as a "small, oval, or roundish, nidus-like benign neoplasm of bone." The majority of the cases are among those in the age group of 11 to 26 years. The femur, tibia, phalanges, astragalus, os calcis, ulna and ilium have been reported as sites. Pain is the primary complaint. Mild and inconsistent in the beginning, it increases in intensity to the point of keeping the patient awake at night. The x-ray reveals a dense sclerotic, radio-opaque zone within a small area of radiolucency. Surgical removal of the lesion is the only successful treatment.

Malignant Tumors

Malignant Tumors of Bone have the following characteristics: They (1) are non encapsulated, (2) grow progressively, (3) infiltrate into surrounding tissues, (4) metastasize to distant parts, (5) are likely to recur, and (6) are most often fatal. The relative frequency of malignant bone tumors is as follows: Osteogenic Sarcoma, 66 per cent; Ewings Sarcoma, 22 per cent; Myelomata, nine per cent.

Medullary and Subperiosteal Osteogenic Sarcomata arise in the shaft and extend beneath the stripped periosteum from a characteristic area of reactive bone formation. Described by Codman, this area is known as Codman's Triangle.

Sclerosing Osteogenic Sarcoma is a clearly defined tumor with a characteristic x-ray appearance. New bone formation is seen in the medullary cavity. The cortical and extra-cortical portions extend into the soft tissues, giving the characteristic "sun ray" appearance.

Although essentially a disease of youth, an osteogenic sarcoma may occur at any age. The majority of these tumors originate in the metaphyseal region of major long bones. About two-thirds of these tumors occur in the lower extremities.

Medullary Fibrosarcoma is a central tumor which occurs usually in the shaft of long bones near the epiphyseal line. The x-ray appearance is inconsistent. There may be irregular expansion of the bone cortex resembling that seen in a central chondroma, giant cell tumor, or the lesion may be osteolytic. These tumors are generally of low grade malignancy and a fair per cent are cured by radical surgery.

Multiple Myeloma is a disease of the skeleton characterized by deformity and weakness of the bones, pain, cachexia and at times revealing Bence-Jones protein in the urine (65-80 per cent). The age incidence of multiple myeloma parallels that of metastatic carcinoma of the skeleton. More than 80 per cent of the cases occur in the fifth to eighth decades, the highest incidence being about the mid-fifties. Pain is the most constant, the earliest, and often the only symptom.

The characteristic feature of the disease roentgenographically is the presence of multiple discrete areas of radiolucency, the lesions being sharply demarcated. They are of central origin and produce no periosteal reactive bone and are resorptive in nature.

The course of the disease extends from 12 to 24 months and is invariably fatal. The diagnosis can be made from marrow puncture or biopsy.

No curative form of treatment has yet been discovered. X-ray therapy, Coley's toxins, radioactive phosphorus and, most recently, the diamidine compounds have been tried with some relief of symptoms.

Every effort should be made to avoid pathologic fractures which add to the patient's discomfort and to the difficulties of nursing care.

Occasional reference is made to *Solitary Plasma Cell Myeloma*. Careful x-ray examination of the entire skeleton discloses only a single bone lesion but, if followed long enough, other areas of bone destruction will probably be found. While some cases of "solitary" plasma cell myeloma seem to run a more prolonged and milder course, the fatal characteristic of myeloma is not altered.

Synovial Sarcomata are malignant tumors arising adjacent to a joint, most frequently of the lower extremity, from a nearby bursa or tendon sheath, rarely from the joint synovial membrane. These neoplasms are rapidly fatal and are usually found in adolescents or young adults. Pain, swelling and dysfunction of the limb are the outstanding clinical features. The x-ray appearance is characteristic and reveals a rounded, sometimes lobulated, sharply defined, soft-tissue tumor mass, with scattered irregular deposits of calcium.

Metastatic Bone Tumors invade the skeleton far more frequently than do primary bone neoplasms. Regardless of the origin of a carcinoma, it may possibly metastasize to bone. Carcinomata which metastasize to bone with regularity are those of the prostate, the breast, the thyroid, the bronchi, the genitalia and hypernephromata.

Secondary bone tumors are of two types: osteolytic or osteoblastic, but most often osteolytic. Osteoblastic sclerotic changes are commonly seen in bone metastases from carcinoma of the prostate.

The vertebrae, pelvis, femur and ribs are the sites most frequently involved in secondary bone neoplasms; next in order are the skull, humerus, sternum, clavicle, scapula and radius. Rarely is the tibia involved. Pain is the most pronounced clinical symptom. Approximately one-sixth of the cases in any large series of metastatic carcinomata of bone will be complicated by a pathologic fracture.

Symptoms referable to bone may represent a malignant condition; early recognition and adequate treatment is essential.

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Licensed Physicians in the U. S

An all-time record number of physicians—218,522—were licensed to practice medicine in the United States at the close of 1953, it was disclosed in the 52nd annual report on medical licensure of the American Medical Association's Council on Medical Education and Hospitals.

Of this total, 156,333 were engaged in private practice, 6,677 were engaged in full-time research and teaching and were physicians employed by insurance companies, industries, and health departments, 29,161 were interns and residents in hospitals and those engaged in hospital administration, 9,311 were retired or not in practice, and 17,040 were in government service.

According to the report, during 1953 there were 14,434 licenses to practice medicine issued by the 48 states, the District of Columbia, Alaska, Canal Zone, Guam, Hawaii and Puerto Rico—an increase of 1,206 over the number issued during 1952 and the third largest number issued in the history of this country. Of this total, 6,565 were granted after written examination and 7,869 by reciprocity or endorsement of state licenses or the certificate of the National Board of Examiners. The majority of those issued by reciprocity or endorsement were to already licensed physicians who moved their practice from one state to another.

The data presented in the report showed that last year 1,276 physicians received their first license to practice medicine. In the same period there were approximately 3,421 deaths of physicians reported, so that there was a net gain of

3,855 in the physician population in the United States and its territories and outlying possessions. During 1952, there was a net gain of 2,987.

The greatest number of licenses issued in 1953 was granted by California—1,977. New York was second with 1,348 and more than 500 physicians were registered in Illinois, Ohio, Pennsylvania and Texas. Less than 50 licenses were issued by Nevada, Delaware, Idaho, Montana, New Hampshire, North Dakota, South Dakota, Vermont, and Wyoming.

From 1935 through 1953, a total of 207,744 licenses to practice medicine was issued in the United States. During the same period there were 119,510 additions to the medical profession—an increase reflecting accelerated programs in medical schools, expanded facilities, and the licensure of foreign trained physicians.

The excellent rating of the nation's and Canada's approved medical schools was pointed up by the number of applicants who successfully passed examinations. Thirteen per cent of the total number of applicants who took written examinations for licensure failed, the report stated. Only 3.8 per cent of the graduates of approved Canadian medical schools failed. In contrast, 50 per cent of those graduated from now extinct medical schools in the United States failed, as did 45.5 per cent of the graduates of foreign medical facilities, 70.2 per cent of graduates of unapproved U. S. medical schools no longer in existence, and 13.4 per cent of graduates of schools of osteopathy.

NOT ARTHRITIS BUT ARTHRALGIA...

If the patient complaining of aching joints is a woman between 37 and 54 years of age, it is highly possible that she is suffering from arthralgia rather than arthritis.¹ It has been estimated that arthralgia occurs in about 40 per cent of women with estrogen deficiency, and is exceeded in frequency only by symptoms of emotional or vasomotor origin.² In fact, arthralgia may be as indicative of declining ovarian function as the classic menopausal hot flushes.

Arthralgia, however, is just one of a vast number of distressing but ill-defined symptoms that may be precipitated by the loss of estrogen as a "metabolic regulator." Other good examples are insomnia, headache, easy fatigability, and tachypnea.

Because these symptoms sometimes occur years before or even long after cessation of menstruation, they are not always readily associated with estrogen deficiency, and the tendency may be to treat them with medications other than estrogen. Obviously, sedatives and other palliatives cannot be expected to produce a satisfactory response if an estrogen deficiency exists. Only estrogen replacement therapy will correct the basic cause of the disorder.

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editor's mail

To the Editor:

I have received from the Medical Association of Georgia a certificate and a very beautiful pin in commemoration of my fifty years of practice of medicine. I appreciate the gift very much, but, doggone it, I hate to be reminded that I am getting so old.

Many thanks.

Cordially,
F. Phinzy Calhoun, M.D.
Atlanta, Ga.

To the Editor:

This is written to congratulate you on the Crawford W. Long Memorial Issue of the Journal. We appreciate all the issues and are glad indeed to possess this special issue.

Dr. Charles S. Kollar, one of the anesthesiologists in the General Hospital (Greenville) has requested me to write asking for another copy of this March number for his personal files.

Sincerely yours,
MRS. JESSIE B. RAY
Librarian, General Hospital
Greenville, S. C.

To the Editor:

I have just returned from the West Coast and Washington and have your very nice note of May 13th. I would like to express my appreciation for the very cordial reception I had in Macon. It was a most enjoyable visit from beginning to end. Please express to the members of your Association my appreciation of the opportunity of being with you.

Sincerely yours,
WALTER B. MARTIN, M.D.
President, AMA
Norfolk, Va.

To the Editor:

On behalf of my father, Dr. Robert V. Martin, I wish to acknowledge your recent letter advising him of his election to membership in the Association's Fifty Year Club.

It would be wonderful if my Father could be present at your 104th Annual Session to receive his certificate and lapel button, however, due to his illness, it will not be possible for him to be there.

My mother joins me in wishing you and the members of the Medical Association of Georgia a most enjoyable Annual Session and continued success.

Very sincerely yours,
ROBERT V. MARTIN, JR.
Savannah, Ga.

TO: Contributor of Heart Page, c/o Editor,
Journal MAG:

"Myocardial infarctions in the thirties are not the rarities they were once considered. There is much factual data extant concerning arteriosclerosis; unfortunately, there is equally as much fancy. As is true of so many unsolved medical problems, there are nearly as many ideas. . . ."

Data is a plural noun. The singular is datum. Also—stratum, strata; memorandum, memoranda, and a good many other such. "On" as well as "um" is changed to "a" in forming many plurals. If you would say there is much horses, or there is much automobiles, then say there is much data; but don't let anybody know you are an M.D.

(Signed)
OLD BACKSWOODS DOCTOR
Charlotte, N. C.

Georgia Hospital Diet Manual

The Georgia Hospital Diet Manual which was prepared with the cooperation of The Medical Association of Georgia, The Georgia Dietetic Association, The Atlanta Dietetic Association, and The Georgia Department of Public Health is now being distributed to the smaller hospitals in Georgia.

It is also being sent to the physicians on the medical staffs of these hospitals. Other copies of this Manual are available and may be secured upon request from the Division of Hospital Services, Georgia Department of Public Health, Atlanta, Georgia.

physician's bookshelf



THE HEPATIC CIRCULATION AND PORTAL HYPERTENSION by Charles G. Child, III, M.D. W. B. Saunders Co., Philadelphia, 1954, 444 pages.

This is an extremely valuable book because it is a comprehensive summary of the vast amount of information that has accumulated in the literature regarding various physiological and pathological states of the liver. An adequate anatomical, embryological and physiological consideration is given to every aspect of the hepatic vasculature. The relationship of these factors to the development of chronic liver disease and portal hypertension is presented very logically and with an abundance of bibliographical reference material. The need for further consulting these references is to a large extent eliminated by the author's expert summaries of the reference material. The physiological basis for the various surgical procedures for the relief of portal hypertension, including the limitations of the procedures, permits the reader to approach these problems in the individual patient with a far better understanding. It is particularly for this reason that the book is to be highly recommended to all students and physicians dealing with this very pertinent problem.

Spalding Schroder, M.D.

BOOKS RECEIVED

SURGICAL FORUM. Clinical Congress of the American College of Surgeons Surgical Forum Committee: I. S. Ravdin, M.D., F.A.C.S.—Philadelphia, Chairman; J. Garrott Allen, M.D., F.A.C.S.—Chicago; Bradford Cannon, M.D., F.A.C.S.—Boston; Warren H. Cole, M.D., F.A.C.S.—Chicago; Robert E. Gross, M.D., F.A.C.S.—Boston; J. Albert Key, M.D., F.A.C.S.

—St. Louis; Carl A. Moyer, M.D., F.A.C.S.—St. Louis; C. Hunter Shelden, M.D., F.A.C.S.—New York; Harris B. Shumacker, Jr., M.D., F.A.C.S.—Indianapolis; Howard C. Taylor, Jr., M.D., F.A.C.S.—New York; Samuel A. Vest, M.D., F.A.C.S.—Charlottesville.

Publication date: April 8, 1954. Pages: 752, illustrated. Illustrations: 131 figures. Price \$10.00.

A MANUAL OF TROPICAL MEDICINE: By Thomas T. Mackie, M.D., Colonel, M.C., A.U.S. (Retired), Chairman, The American Foundation for Tropical Medicine. George W. Hunter, III, Ph.D., Colonel, M.S.C., U.S.A., Chief, Section of Parasitology-Entomology, Fourth Army Area Medical Laboratory, Brooke Army Medical Center, Fort Sam Houston, Texas. C. Brooke Worth, M.D., Field Staff Member, Division of Medicine and Public Health, The Rockefeller Foundation. New, Second Edition. 907 pages with 304 illustrations, 7 in color. Philadelphia and London: W. B. Saunders Company, 1954. Price \$12.00.

FUNDAMENTALS OF OTOLARYNGOLOGY—A Textbook of Ear, Nose and Throat Diseases: By Lawrence R. Boies, M.D., Clinical Professor of Otolaryngology; Director of Division of Otolaryngology, University of Minnesota Medical School. New, Second Edition. 487 pages with 197 figures. Philadelphia and London: W. B. Saunders Company, 1954. Price \$7.00.

ILLUSTRATED REVIEW OF FRACTURE TREATMENT, Liebolt, Frederick Lee, Los Altos, California, Lange Medical Publications, 1954, First Edition, 225 pages, \$4.

Pamphlets Promote Medicine's Story

To help you tell medicine's public relations story to your patients, the American Medical Association announces the publication of a series of four new leaflets describing medicine's scientific achievements, services to the community and desire to provide high quality medical care to everyone.

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about medicine's progress in the past 50 years; (3) "On Guard!"—outlines the steps AMA has taken to evaluate drugs, and (4) "Why Wait?"—describes the best way to select a family doctor.

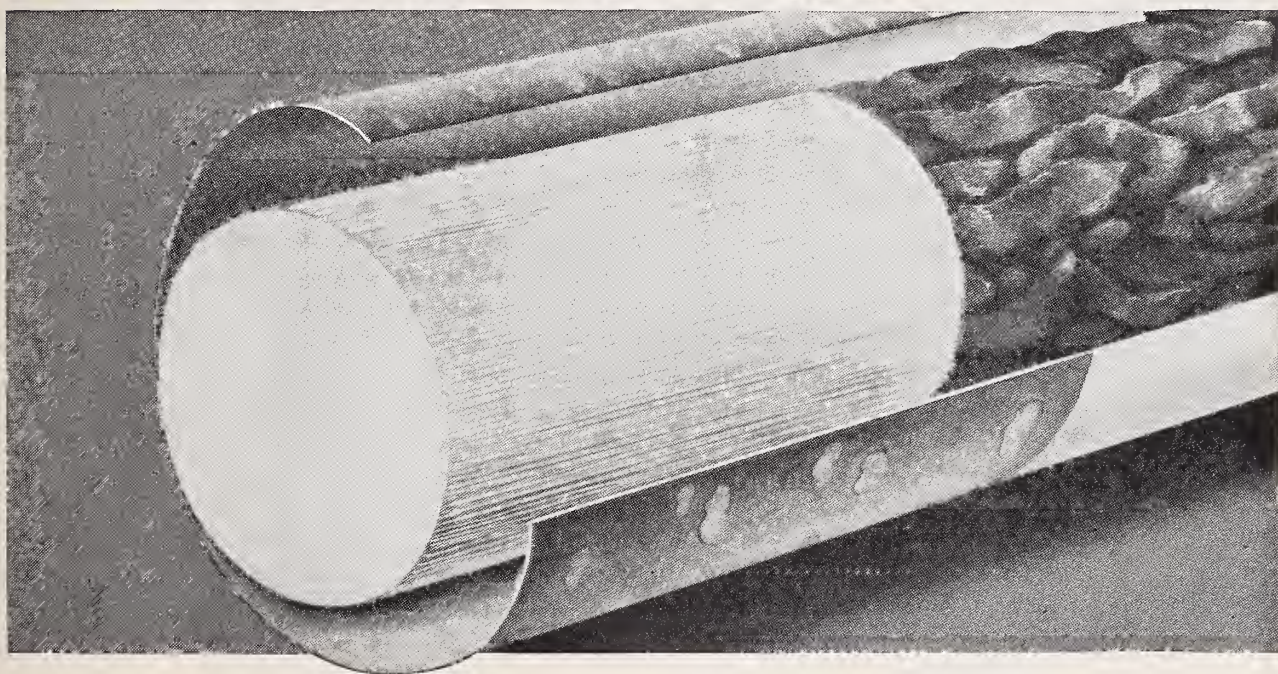
Available in quantity, these little pamphlets are suitable for distribution in your waiting room, as enclosures or as give-away material at schools and other general meetings. You may order either the entire series or individual leaflets—without charge—from your state medical society.

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Attention, Committeemen!

THE THEME OF THE RECENT June 5-6 meeting of the Council of the Medical Association of Georgia concerned reports of MAG committee chairmen with regard to their projects and plans for the '54-55. The chairmen appeared before Council at the request of MAG President Peter B. Wright. Committee chairmen were advised that this was the "kickoff" for their year's committee work.

Each year the incoming MAG President hand-picks committee chairmen and committeemen to accomplish the goals of his administration. Those committees already operating efficiently are usually left unchanged. Committees which have been inactive are changed. New leadership often sparks a committee into action.

To serve as a committee chairman or committeeman is a privilege—a privilege that carries the responsibility of tackling a job and seeing it

through. By accepting a committee appointment the physician shows his willingness to give of his time and talent—to further the ends of the Association. It is through committee effort that the Association progresses.

The June 6th Council meeting served to notify all committees that the 1954-55 program of the Association rests in their hands. If progress is made during the next year, it will be through the MAG committee efforts. All committees are expected to meet at least once during the summer so that their projects will be underway by fall of this year.

The responsibility of the MAG program rests squarely upon the shoulders of the committee chairmen and the committeemen. Make this year meaningful by immediately "digging in" on the job your committee has before it.

Hydrocortisone in Dermatology

IT IS PROBABLY FAIR to say that the development and proper use of the hydrocortisone ointments is one of the most important advances ever made in dermatological therapy. This, however, does not mean that it can be prescribed with hope and confidence for every itching hide like a patent medicine with a shot-gun formula. In fact, the key to its great value lies in the conservative use in a limited number of dermatoses—not in prescribing it willy-nilly to everything that is labeled "eczematous" or "allergic". This latter kind of abuse of good things has been, and is, one of the chief criticisms that can be made of the palpably unscientific, unthoughtful mind of the physician, who like a hungry fish grabs at the first moving bait that looks like food.

Like most hormones hydrocortisone is absorbed in minute quantities through the skin, and a given quantity will be useful only for the moment—repeated use of small quantities in small percentages

in the vehicle then would appear wise and large quantities and large percentages of hydrocortisone would appear to be wasteful and expensive.

The use of this hormone on oozing, weeping, or vesicular eruptions would also appear to be of little value and wasteful.

Its use in such well defined conditions as scabies, dermatophytosis, and infections of the skin would appear useless. *Some* evaluation of the patient's dermatosis must be made before prescribing it over the telephone.

Hydrocortisone seems to be a nice hormone when applied to the skin since there is no report of extensive systemic absorption or skin sensitization.

We have more or less "simmered down" in the abuse of cortisone and ACTH, and now appreciate the wondrous helpful qualities in specific situations—and undoubtedly so it will be with the dermal application of hydrocortisone.

Policies of the JMAG

AT A RECENT MEETING of the Editorial Board, it was decided that the policy of geographic distribution of contributing editors throughout the state should be continued with appointments being made on a yearly basis. The previously established deadline of the 15th of the month previous to publication will be observed on a stricter basis to insure an earlier publication date.

In the future authors will be asked to submit papers in triplicate so that their processing may be speeded up. All papers will be given every possible consideration for publication; unsolicited papers will be given equal consideration with those presented at the Annual Session. A paper is never returned on the judgment of a single person and is not necessarily a reflection on the quality of the paper but may reflect on its suitability for publication in a state journal. Many

more papers are submitted than can possibly be published. It follows then that the greater the number of papers submitted, the better will be the final selection of material published in your *Journal*. It is hoped that even more papers will be contributed in the future.

Finance wise, the *Journal* is self-supporting, and is not operated to produce a profit. Printing costs are carefully balanced against advertising revenues each month. A survey of *Journal* readability has recently been completed in the 9th District with some interesting findings which are reported in the Association section of this *Journal*. More surveys are contemplated in other parts of the state. Constructive criticism of *Journal* content and policy is welcomed.

With your help your *Journal* will continue to hold its position with the best state medical journals.

The San Francisco Meeting

A detailed report of the business activities of the AMA House of Delegates at their recent meeting in San Francisco, June 21-25, will be presented by the MAG Delegates C. H. Richardson, Eustace A. Allen and Spencer Kirkland in an early issue of the *Journal*. This colorful report was forwarded to meet a delayed deadline by MAG Secretary-Treasurer David Henry Poer for inclusion in this issue. Quoting Secretary Poer, "Below I have given some general impressions of the AMA San Francisco convention as seen by an M.D. without portfolio."

Arrived Oakland, California, early Monday morning ours was the largest delegation traveling as a group, with 118 physicians and families on the Moyers Southern AMA Special train. The view of San Francisco from the ferry included famous landmarks—Alcatraz Island, Telegraph Hill, the Mark Hopkins Hotel and the Oakland Bay Bridge (longest in the world with a span of eight and one-half miles).

Then on to the hotel where confusion reigned. All the major hotels were oversold by 100 or more confirmed, money-on-the-line reservations. Apparently the hotels had turned no one down for

hotel space in their enthusiasm to get the physicians out here. As a special note to the San Francisco Chamber of Commerce, I believe someday the system will backfire! The only way to beat the chaotic system of making room reservations is to plan to arrive several days in advance.

In the Convention Hall more overselling was obvious as many exhibits were housed in a tent in the street, which had been blocked off for this purpose. There were more exhibits than anyone could possibly visit in a month crowds, demonstrations, samples, free drinks (soft, that is), students, internes, nurses, technicians queues for choice cosmetics, a beautiful Cadillac free for some lucky M.D. to drive home and still crowds and chaos.

Scientific exhibits galore . . . acres and acres of discoveries, observations, explanations. Enthusiastic M.D. exhibitors had tired feet but were still able to carry on the carnival-like spiel. The Gold Medal award was given to Drs. DeBakey and Creech (Oscar Creech was a surgical guest speaker at the MAG Macon meeting). Other awards for excellent work were given and viewed in spite of the ever milling crowds in the exhibit area.

Section meetings and general meetings all with excellent programs provided a real graduate education. Business meetings and politics and best of all, greeting old friends. Old friends from "good old Army days" with their counterpart evidenced by the many young M.D.'s still in uniform.

And then sightseeing starting at Union Square—remember the stately St. Francis, Gumps, the five story garage all underground (when will other cities take note?). These dinky cable cars still clank and jerk their way up Powell Street, and another line on California transfer on top of Nob Hill and down to Chinatown. See block after blocks of shops filled with "toorist" junk to send home as souvenirs. See the Chinese bakeries, meat shops and the little children at their street games. On then to Coit Tower, to Fisherman's Wharf, sea food headquarters of America, where crabs are cooked in front of you along the open street.

In and among the crowds made up of mostly AMA people recognized by their badges more souvenirs to buy and throw away. To Tarantino's with lines of people waiting to get in—and then the trek back to the hotel. Exhausted, but not too tired to stop by the "Top of the Mark," a cocktail wonderland which is a must

even for those imbibing nothing stronger than lemonade.

Took a last look at the Fairmont, for years one of the country's best hostelryes filled with many "unusual" eating and drinking places including the famous Merry-Go-Round Bar.

On down the hill then, wondering if the little cable car had ever had its complicated brakes fail (has happened), and hoping the C. of C. would forever insist the archaic cable cars remain even if taxes be raised to pay for them.

On the not so enthusiastic side are some notes which usually go along with any big meeting. Wondered why so many of the good eating places (Cliff House, several other restaurants and hotels) ran out of many food items including such staples as milk and bread. It also seemed that prices were "jacked up" for the occasion (laundry, terrific, and \$7.50 for dry cleaning one single dress). The service in the eating spots suffered with overcrowding as no one was turned away and reservations were meaningless.

Finale counting all the good and bad impressions our group admitted that San Francisco is still the most wonderful city in the country to visit, with more interesting highlights and spots to see. And when the good old AMA comes to San Francisco in 1958, you will find the Georgia delegation the first to join the parade.

Encourage Righthandedness

Children should be encouraged to be right-handed when they are about one year of age, a medical consultant wrote in the current (May 22) Journal of the American Medical Association.

"The infant has no definite sidedness, either left or right; he is ambilateral, not ambidextrous, and both sides are inept," he stated. "A one-sided pattern begins to emerge at about 18 months and continues to develop for many years as one-sided skills are learned.

"Since our culture (customs, tools, etc.) is right-sided, the child should be encouraged to right-sidedness from the very beginning. According to this view, it is wrong to let the child choose for himself, as there is a 50 per cent chance that he may accidentally select the wrong side. However, this encouragement must be done pa-

tiently and kindly, not forcefully. Otherwise, negativism is excited in the child that may in itself lead to left-handedness and other personality difficulties.

"Similarly, contrariness due to other factors may also express itself in left-handedness. Once the pattern is habituated for certain activities, it becomes more or less ingrained. However, sidedness is not always uniform and mixed laterality for different activities is not uncommon.

"Each introduction of new activities offers an opportunity for rightsided training, especially for significant activities, e.g., writing at the beginning of school. Retraining done kindly and patiently is always possible in childhood (in school for writing) and even later (as in the war injured), and no ill-effects may be anticipated."

Your AMA Is What You Make It

WALTER B. MARTIN, M.D., Norfolk, Va.

THE AMERICAN MEDICAL ASSOCIATION came into being on May 7, 1847. A truly national representative medical organization was born on that historic date. In the beginning there was considerable debate as to whether the control of the organization should be in the hands of a perpetuating body of officers and trustees, or a group of representatives from state and local societies. It was fortunate indeed for American medicine that the second viewpoint prevailed. In the preamble to the constitution, drawn up at that time, the following statement appeared as to its purpose: "For cultivating and advancing medical knowledge, for elevating the standards of medical education, for promoting the usefulness, honor and interest of the medical profession, for enlightening and directing public opinion in regard to the duties, responsibilities and requirements of medical men, for exciting and encouraging emulation and considered action in the profession and for facilitating and fostering friendly intercourse between those engaged in it."

Dr. William Welsh in his presidential address in 1910 expressed his great confidence in the beneficent effects of the American Medical Association in these words. "Among the organized forces for advancing the prosperity, the happiness and the well-being of the people of this country, the American Medical Association has an important part to play. We are justified in the confidence that, with the united support and loyalty of the profession, this association, broadly representative and standing for the best ideals of medical science and art and for professional and civic righteousness, will contribute a beneficent share to the working out of our national destiny."

While over this period of more than a hundred years, the American Medical Association has expanded in number and influence, the principles and ideals here enunciated still prevail. It now has a membership of 144,000 physicians, and is made up of 53 constituent state and territorial societies. These in turn are composed of 1972 component county and district societies. The democratic character of its policy-making body has been preserved. Each county society is a true democracy and in a sense is like the old town meeting. Every member can participate in its deliberations and can have a hand in controlling its policies. I think it is worthwhile to remind you that of the 1972 county and district societies, 1705 have a membership of less than 100, and only 113 of all of the county societies in the United States have a membership of over 500. I believe this illustrates the powerful influence that the small local societies can have in formulating the policies and directing the destiny of the American Medical Association. These smaller societies elect a majority of the delegates to the state societies, which in turn elect the representatives of the various states and territories to the House of Delegates of the American Medical Association. This national House of Delegates formulates and declares all policies of the Association and elects the general officers and members of the Board of Trustees. The House of Delegates elects its own speaker and operates under rules of order and procedure determined by itself. Numerous reference committees are appointed by the Speaker of the House and to these reference committees are referred for careful study, all resolutions introduced into the House of Delegates, all communications coming from the officers of the Association, Board of Trustees, and all reports of the councils and bureaus of the Association. These

Read before the General Session at the 104th Annual Session of the Medical Association of Georgia, Macon, May 3, 1954.

The AMA President Speaks to You

matters are considered in open session by the reference committees. In their report to the House of Delegates they may approve or disapprove any of these reports and resolutions, in whole or in part, and may make definite recommendations to the House of Delegates. The report of each reference committee is subject to debate and final passage, amendment or rejection, by the majority of the delegates present and voting. It is further emphasized that the delegates are very conscious of their duty and there are never more than a scattered few who are not present at all meetings of this body.

Every member of the local county or district society has the privilege of attending society meetings and of participating in the election of representatives of that society to the state House of Delegates. He has the privilege of introducing resolutions for or against any matter that he feels concerns medicine, of urging its adoption, and if adopted, of directing his representatives to introduce it in the state House of Delegates. There it may pass on to the national House of Delegates where it may prevail or be rejected through the process described above. Any member of the Association has the privilege of attending the sessions of any reference committees and of supporting or opposing any matter under their consideration.

The American Medical Association is what you make it. It is your organization, set up on democratic principles. The line of authority extends from the county society to the state society and to the House of Delegates. The officers of the organization and its Board of Trustees carry out declared policies of the Association as set up by the House of Delegates. There is no chain of command extending from the American Medical Association to the state association and down to the county level. The national organization will inform you and urge you but it cannot direct you. The A.M.A. is what you have made it in the past and what you desire to make it in the future. The strength of the American Medical Association is dependent upon the strength, understanding and cooperation of the state and local societies in carrying out the purposes and principles adopted and declared by your national House of Delegates.

The A.M.A. and the county society are mutual-



Walter B. Martin, M.D.

ly dependent upon each other. You look to your national organization for leadership, information and guidance in many fields, while it looks to you for support in carrying out its proper policies. It seems worthwhile to discuss this relationship and to point out certain areas where we are and can be helpful to each other. The declared policy of the A.M.A. is to advance the art and science of medicine and thereby improve the health of the public. In order to accomplish this, it encourages research, supports the teaching of medicine and endeavors to promote continued advance in both the prevention and treatment of disease. It must do more, however. It must improve and protect an environment necessary for the continued advancement of the art and science of medicine. History records many instances where the advances of medicine have been halted and thrown back by changing economic and political conditions. If medicine is to continue to advance, the A.M.A. and the county society must work together and must be mutually helpful.

How does the A.M.A. help the individual physician and your county society? Through its Council on Medical Education and Hospitals it stands guard over the portals of medicine. It gives assurance to you and the American people that high standards of medical education are maintained. Class B schools have ceased to exist and

medical education as a whole is now at a higher level in the United States than in any other country in the world. This council established standards for intern and residency training and has brought about great improvement in post graduate medical training and education. More recently, in conjunction with the American College of Surgeons, the American College of Physicians, the American Hospital Association and the Canadian Medical Association, the entire field of hospital inspection and standardization has been coordinated under a joint commission. The work of the Council has assured the American people of a constant flow of highly trained physicians. The smooth working of this program of accreditation of hospitals requires the loyal support of local groups and societies and a sympathetic understanding of local conditions and needs by the commission and its representatives.

Through the Council on Scientific Assembly and the Bureau of Exhibits, the A.M.A. conducts a great educational program at its annual and interim meetings. These programs cover all of the fields of medicine and provide a means by which physicians from all parts of the country can keep themselves abreast of modern medicine. Continued medical education is carried on by the Journal of the A.M.A. and its nine special journals that bring to your office, weekly and monthly, the latest advances in your profession. The organizational section of the Journal of the A.M.A. keeps you informed as to proposed and pending legislative activities affecting medicine and of the testimony of our representatives before committees of the Congress. Its large reference library is at the service of each of our members who desires to consult it. The quarterly accumulative index provides ready access to the latest medical literature.

Through its Council on Pharmacy and Chemistry the A.M.A. protects the physician and the public against useless or dangerous drugs. The Council on Food and Nutrition and the Council on Physical Medicine and Rehabilitation offers the same protections in the field of foods, apparatus and appliances.

The Bureau of Investigation, the Bureau of Legal Medicine and the Bureau of Health Education render a great and useful service to you and your patients.

With the great expansion of industry has come an increase in industrial hazards. The Council

on Industrial Health is very active in the study of such hazards and in advising means of elimination. This council is not to be confused with the committee on the health of industrial workers, which is concerned with the medical care aspect of the health of industrial workers.

There is another group consisting of activities that are concerned with the problem of medical service. Many of these are grouped under the Council on Medical Service and give special attention to extension of health facilities, prepayment hospital and medical care plans, indigent care, maternal and child welfare, lay sponsored voluntary health plans and Federal medical services.

The Council on Rural Health has carried on a constantly expanding program and, in conjunction with farm and other rural agencies, has made many worthwhile contributions in the direction of improving the health of people in the rural areas.

One of the most useful activities of the A.M.A. and of a number of states is the physicians' placement service. This service in my own state is operated by our state council on Health and Medical Service. This council, while not operated by our state society, is given generous support by that society. In addition, more than a fourth of our members are individually contributing members of the council. This placement service has been so successful that at present it has many more applications from physicians seeking placement than from communities in need of a physician.

The Council on Emergency Medical Service does not concern you directly, but its contribution in this field may be in later times of very significant interest to you.

The Washington office of the A.M.A. has become increasingly important. The number of bills before Congress concerned with health matters is constantly increasing. The development of accurate and detailed information concerning these proposals and the dissemination of this information to state and county societies is of primary importance. Unless you know what is going on in Washington, how can you think or plan or act? In addition, this office collects and makes available to members of Congress pertinent information on medical subjects. The work of this office deserves your wholehearted support.

These are some of the things that the A.M.A. is doing for the state and county societies and for you. In return there is much that each county society can do for the public and for the A.M.A.

The county and district societies are 1972 in number, but it is important to remember that over 1700 of them have less than 100 members. I feel that these societies are the really important ones. These members as a rule are much closer to the people they serve and have a greater opportunity to play an influential part in the life of their community.

What can the county society do to best serve the public and to carry out the policies of the A.M.A.? Perhaps it is best to get down to particulars. The county society through its members can take an active part in all agencies concerned with community welfare, particularly those that have a connection with health. It can promote the formation of health councils and interest itself in the public health phase of medicine. It can work with the local health department in improving and extending public health services in each community. It can stimulate its members to activity in civic clubs, religious organizations and in the educational field. Individual members can support the Community Fund or Chest with contributions of time and money. Through all of these activities, the county society can make itself felt in every worth-while phase of community life.

The county society and its members should also be aware of the needs of their community from the standpoint of hospitals and other medical facilities. They should try to improve the quality of existing facilities and to extend them when the need exists. It should be the objective of the county societies to improve their communities in every way that will promote the total community welfare and make it a more desirable place in which to live.

The county society should constantly endeavor to improve the quality of medical care in the community and to improve the professional status of its members. Through scientific meetings, journal clubs, hospital staff meetings and by encouraging qualified younger men to come into an area where they are needed, the general level of medical practice can be consistently improved.

It should keep a kindly but watchful eye on the quality of practice in its community and, through suitable committees, adjust differences when they arise between physicians and their pa-

tients and should make provisions for adequate emergency service.

The rapid expansion of voluntary pre-payment insurance against the cost of hospital care and the medical and surgical care in the hospital has been one of the striking developments of the last 20 years. At the present time over 90 million people have some type of coverage against hospital costs, 70 million against surgical and 35 million against medical care in hospitals. These figures are still expanding. It is notable that the highest percentage of coverage is in the highly industrialized states and in the great industrial centers. Coverage has lagged in the towns and rural areas. The county society can do a great service by surveying its own area and by working out plans to extend to a greater degree the benefits of the voluntary pre-payment plan in its own community.

Abuses have developed in the field of pre-payment insurance, and the county society can promote community welfare by aiding in the correction of these abuses. If voluntary pre-payment fails to accomplish its full purpose, it will be because of such abuses as unnecessary hospitalization, prolongation of hospital stay, and over-use of the special hospital services. The effect of over-use is to increase the total hospital and professional cost to the community. This cost is bound to be reflected in increased insurance rates or depreciation in quality of hospital care. It will eventually be influential as a result of higher premium charges in retarding sales of this type of coverage. Failure of the pre-payment plan to continue to expand, particularly in non-industrial areas not now well covered, will result in increased pressure for further extension of the federal government in the field of medical care.

The importance of helping to build up facilities in each community, capable of caring for all the people of the community requiring care, cannot be over emphasized. There is, of course, a small group of patients who will, because of the nature of their illness, have to be transferred to larger and more fully staffed institutions.

In this day of rapid advances in the science of medicine, full use must be made of modern methods but other and more important attributes of medicine must not be lost. Medicine to meet the needs of the people and to satisfy their desires must be personal. We speak rather glibly of the physician-patient relationship often without considering its meaning or how a proper relationship is to be maintained. It is based on a mutual re-

gard between the physician and the patient, a regard by the physician for a particular individual with a medical problem that harasses him and a regard by the patient for the physician as a man of skill and sound training, an honest man, and a kind and understanding man. The development and maintenance of this type of relationship can only be accomplished by the local society.

The American Medical Association and the county societies acting through their state societies are mutually inter-dependent. Your A.M.A. is what you make it. There are many problems facing medicine today. They are concerned with the science of medicine and the practice of medicine, doctor-hospital relations, the financing of medical care, medical education, intern and residency training, extension of facilities and the growth of federal medicine to mention only a few. The American Medical Association is in a position to make studies, compile facts and give you information on which you can base your judgment. It may formulate policies, but it cannot put them

into effect without your support and cooperation. We do not ask that you necessarily support them. We do ask that you be active in your local association, that you inform yourself and that you assume the full privileges and duties of an American physician. The one main policy of the American Medical Association is to work for the constant advancement of the art and science of medicine and by so doing bring better health to all of our people. As long as our policies are founded on this concept and are not colored by self-interest, they deserve your support. If you believe in these policies you should support them. If you do not believe in them you should not indulge in careless and destructive criticism, but you should work in an orderly way to change these policies. The strength of the American Medical Association is now and always has been in the local medical society. Your A.M.A. is what you make it.

521 Wainwright Building

Causes of Deafness in Children

Much has been learned in the last few years about permanent deafness in young children, with a resultant change in the believed causes of such deafness, according to Drs. Edmund P. Fowler and Milos Basek, New York.

Writing in the current Archives of Otolaryngology, published by the American Medical Association, the doctors described a study of 270 deaf children under the age of 10 years; in all but two cases deafness began before the child was five years of age. The report showed that in 81 cases deafness was caused by prenatal conditions and that in 189 cases it resulted from post-natal conditions.

Among the 81 cases of prenatally caused deafness, 10 resulted from such conditions as hereditary deafness and syphilis. Fifty children became deaf as a result of conditions which occurred during pregnancy. These included German measles, Rh blood factors, emotional causes (excessive vomiting), use of abortives, and convulsions. Deafness occurred from the effects of labor in 21 cases; these included infections, birth injury, excessive use of drugs, and cyanosis after birth.

Postnatal deafness occurred in 45 children following inflammation of the middle ear. Thirty-nine children became deaf following high fever and such infectious diseases as meningitis, mumps and measles. Drugs and poisoning caused deafness in eight cases, and 11 children developed deafness following such conditions as a fractured skull, Meniere's disease, leukemia, and cerebral degeneration. In 86 cases, the exact cause of deafness was unknown.

"A look through the older literature on the etiology of deafness makes it obvious that a great deal has been learned in the last few years concerning loss of hearing in young children," the doctors wrote. "The causes of deafness have apparently changed, so that they are no longer dominated by septic meningitis and scarlet fever in the acquired list.

"Furthermore, the old 'scrapbasket' called 'congenital deafness' has been cast away, to be replaced by the modern theories of malformation and congenital anomalies."

The doctors are associated with the Babies Hospital of the Columbia-Presbyterian Medical Center.

Acute Pancreatitis

A Survey of Diagnosis and Treatment

of a Common Cause of Acute Abdominal Pain

JAMES T. McDONALD, M.D., and WILLIAM H. FREEMAN, M.D., Athens, Ga.

ACUTE PANCREATITIS is one of the most common causes of severe upper abdominal pain and frequently the least recognized. This disease is often diagnosed as acute cholecystitis, perforated peptic ulcer, acute intestinal obstruction, coronary thrombosis, and acute gastroenteritis. Grollman et al reported 45 cases of acute pancreatitis and only 13 to 28 per cent of these cases were diagnosed correctly. In our series of 28 cases the correct diagnosis was made in only 38 per cent of the cases. An improvement on these percentages can not be expected until the attending and house staff become pancreatic conscious and use appropriate laboratory tests.

TABLE I
ADMISSION DIAGNOSIS 27 CASES
ACUTE PANCREATITIS

	Watts	Cin. G..
Acute Cholecystitis	6	14
Per. Pep. Ulcer	3	6
Acute Appendicitis	3	0
Coronary Occlusion	2	6
Acute Gas-enteritis	1	0
Pneumonia	1	0
Acute Int. Obst.	1	6
Acute Pancreatitis	10	13
CORRECT DIAGNOSIS	37%	28%

Types of Acute Pancreatitis

TYPE I. Acute edematous pancreatitis is characterized by edema of the pancreas and peripancreatic tissue with an associated vascular engorgement. Fat necrosis may or may not be present in this type.

TYPE II. Acute hemorrhagic pancreatitis is a more severe form and some observers are of the opinion that it is a progression of type one. The pancreas is swollen and hemorrhagic with marked

exudative reaction and generalized fat necrosis.

TYPE III. Acute suppurative pancreatitis is characterized by a diffuse necrosis of the pancreas and occasionally abscess formation in the adjoining tissues. This type may well represent a progression of types one and two. Complications such as abscess and pseudocyst formation are seen more commonly following this type.

TABLE II
TYPES OF ACUTE PANCREATITIS
Type I. Acute Edematous Pan.
Edema, fat necrosis
Type II. Acute Hemorrhagic Pan.
Type I plus hemorrhage,
peritonitis, and exudative
reaction.
Type III. Acute Suppurative. Pan.
Type I and II plus necrosis
and suppuration

Etiology

Theories regarding the etiology of acute pancreatitis are many. It is interesting to speculate on them from an anatomical and physiological viewpoint. The most widely accepted theory is the common channel theory with regurgitation of bile secondary to ampullary blockage. This was first demonstrated by Opie⁷ in 1901. Cameron and Noble¹ investigating the anatomy of the common bile duct and the duct of Wirsung found a common channel in 74 per cent of 100 autopsies. Howard and Jones⁶ studying dissections of fresh autopsy specimens found this type of regurgitation possible in 54 per cent of 150 cases. Reinhoff and Pickerell¹¹ in 250 autopsy specimens found this anatomically possible in only 17 per cent of the individuals. In his original work Opie showed

that a common duct stone lodged at the ampulla of Vater produced the obstruction which resulted in regurgitation of bile into the pancreatic duct. However, since this time other workers have postulated that the obstruction may be due to spasm of the Sphincter of Oddi, edema of the duodenal mucosa and possibly intestinal parasites. Doubilet and Mulholland² feel that the post-cholecystectomy syndrome is actually an attack of pancreatitis produced by spasm of the Sphincter of Oddi. Rich and Duff¹⁰ feel that blockage of the pancreatic duct by squamous metaplasia may be the predominant etiologic factor. Blockage of the pancreatic duct produces an increased pressure in the smaller duct radicals and subsequent rupture of the acini with the liberation of pancreatic enzymes into the interstitial tissue and peripancreatic tissue. The process is more likely after a heavy meal, when the volume of pancreatic juice is greatest.

Other theories which have been suggested as possible etiological factors are: (1) the spread of infection by lymphatics from the gall bladder, (2) infection spread by direct continuity from adjacent structures such as duodenal ulcer, (3) an aberrant infection of the virus of infectious hepatitis, and (4) chronic alcoholism.

TABLE III

THEORIES OF ETIOLOGY

1. Common channel theory
 - a. Stone
 - b. Edema duodenal mucosa
 - c. Spasm
 - d. Parasites
2. Blockage Pan. Ducts by Squamous Metaplasia
3. Infections from
 - a. Gallbladder—Lymphatic
 - b. Duodenal Ulcer-continuit
 - c. Virus of hepatitis
4. Chronic alcoholism

Pathological Physiology

Whatever etiological agent is responsible, the pancreas reacts pathologically as any other organ involved in an inflammatory process. It is the opinion of the authors that obstruction to the flow of pancreatic juice, whether at the Sphincter of Oddi or in the pancreatic ducts, is the basic etiological factor. An obstruction of pancreatic flow produces a back pressure in the smaller pancreatic radicles with rupture of the acini. When the pancreatic acini rupture and irritating pan-

creatic enzymes are released into the interstitial tissue, the inflammatory process is initiated. At the onset edema and vascular engorgement predominate, producing distention of the capsule and irritation of the posterior peritoneum. The process may subside at this point, but recurrent attacks are likely to occur.

If the above process continues there results pressure on the pancreatic vessels with ischemia of the parenchyma and subsequent necrosis. This in turn releases more damaging pancreatic ferments. As a result of necrosis some of the pancreatic vessels may rupture producing hemorrhage into the parenchyma. The hemorrhage may be localized, or it may involve the entire gland. Marked fat necrosis and exudative reaction are produced in the surrounding tissues. This stage is commonly known as acute hemorrhagic pancreatitis. Type III, or acute suppurative pancreatitis, frequently develops if secondary bacterial invasion is added to the ischemia and necrosis. This stage may progress to abscess formation of the pancreas or adjacent tissues.

The authors are of the opinion that the three types of pancreatitis described are manifestations of the same disease. It is impossible to predict which course the disease will follow. Some patients recover completely, while others run a rapidly fatal course. The acute process may subside and be followed by a chronic pancreatitis with or without pancreatic calculi. In the more severe forms abscess, pseudocyst formation and marked fibrosis are the most common complications.

Clinically acute pancreatitis may simulate a coronary occlusion or any acute upper abdominal condition. Frequently there is a history of similar previous attacks of less severe abdominal pain and many patients give a history of onset following a heavy meal. Attacks may or may not follow a recent episode of excessive alcohol ingestion. In our series, a history of alcoholism was present in 25 per cent of the cases. The incidence of associated gall bladder disease is about 60 per cent, as reported by Doubilet and Mulholland.²

Pain which is severe, constant and localized in the epigastric region and umbilical area is the most characteristic finding. The pain may be greater on the right or left side and radiation to the back is quite common. Frequently it is so severe that large doses of opiates fail to give relief. Nausea

and vomiting accompany the pain in the majority of cases.

On physical examination the patient may present a picture of varying degrees of shock, depending on the severity of the disease process. The major physical findings which are limited to the upper abdomen, consist of tenderness, involuntary muscle guarding, and varying degree of paralytic ileus. There is seldom a palpable mass present and the temperature is rarely elevated over 102°.

TABLE IV

SYMPTOMS	NO.	CASES
Abd. Pain	26	96%
Nausea and vomiting	25	92%
Back pain	11	41%
Associat-alcoholism	7	26%
History pre. attack	4	14%
After heavy meals	4	14%
Collapse	4	14%

TABLE V

PHY. FINDINGS	NO.	CASES
Tenderness		
Direct rebound	26	96 %
Rigidity	19	70.3%
Distention	15	55.5%
Temperature over 100	12	44 %
Absent Peristalsis	10	37 %
Palpable mass	5	18.5%
Jaundice	4	14 %

Laboratory Aids

The most important laboratory test is the serum amylase determination, which, if elevated during the first 48 hours, is presumptive evidence of acute pancreatitis. However, one must be aware that serum amylase elevations may be due to renal retention, salivary duct obstruction and suppurative salivary adenitis, pancreatic carcinoma or a perforated duodenal ulcer. The importance of getting an early blood amylase determination can not be stressed too much, for the amylase level rises within 8-12 hours after onset of the illness and drops to normal levels within 48-72 hours. Daily blood amylase determinations are helpful but cannot be considered as an indicator of the course of the disease. There are several methods of performing the amylase determinations, however, we feel the Somogyi method or a modification thereof as advocated by Probst and Sachar⁹ is more accurate. This test is simple and determinations may be obtained within approximately 30 minutes. Using the modified Somogyi method the normal blood amylase is 80-150 units per 100 cc. plasma. An elevation of 300 Somogyi

units are considered pathognomonic of acute pancreatitis.

Urinary amylase values rise later and remain elevated longer than the serum amylase values. The test is performed on urine in the same manner as on blood serum. In patients who are seen after 48-72 hours, this test is more valuable than the serum amylase determination.

Serum lipase values are elevated in acute pancreatitis and remain so for a longer period of time than serum amylase values. However, the test is more difficult to perform and it takes 24 hours to complete. This may be useful in suspected cases in which the amylase level is normal.

Edmonson and Berne³ studied the serum calcium levels in acute pancreatitis and found levels lower than normal and if serum calcium levels reach seven mgm. per 100 cc., this is regarded as a serious prognostic sign. The pancreatic lipase hydrolyzes the fat into fatty acids which are combined with ionized calcium to form the white plaques of "fat necrosis." This increased mobilization of calcium in and around the pancreas may explain the lowered serum calcium levels.

The leucocyte count is usually elevated, ranging between 10,000 and 20,000. The icterus index was elevated moderately in 30 per cent of cases reported by Sullens and Lichtenstein.¹³ Albuminuria and glycosuria are not uncommon findings in the severe cases.

X-ray studies of the abdomen may show a "sentinel" dilated loop of jejunum in 15-20 per cent of cases.⁵ When calcific deposits are seen in the region of the pancreas, one must suspect a recurrent pancreatitis. With x-rays, other conditions such as perforation of a duodenal ulcer and intestinal obstruction are more easily excluded as possibilities.

TABLE VI

LABORATORY DATA	
1. Blood amylase	
2. Blood lipase	
3. Urinary amylase	
4. WBC	
10- 20,000	44%
Under 10,000	33%
5. Albuminuria and glycosuria	

Treatment

We feel that the treatment of acute pancreatitis is medical unless complicated by late abscess or pseudocyst formation, at which time surgery is indicated. Siler and Wulsin¹² reported 111 cases

with a total mortality of 18 per cent following the above regimen. Sullens and Lichtenstein¹³ reported 50 cases; 24 were operated upon with a mortality of 41.6 per cent, 26 were treated conservatively with a mortality of 26.9 per cent. These figures compare favorably with those reported by other authors.

In the acute stage, relief of pain is accomplished by the administration of demerol or papaverine, which reduces spasm of the Sphincter of Oddi. Morphine is contraindicated as it increases the spasm of the Sphincter of Oddi, thus increasing the pain. Intra-gastric suction is employed to alleviate the accompanying distention and to decrease the amount of gastric juice entering the duodenum, which may stimulate the pancreas. Oral feeding is withheld, as this tends to increase pancreatic secretion. Blood, plasma and glucose are used as needed to combat shock and dehydration. Atropine, 1.3 mgm. every three or four hours, inhibits the vagus, thus inhibiting pancreatic function, and relaxes the intestinal tract and the Sphincter of Oddi. Banthine, orally or parenterally, in dosages of 50 mgm. every six hours may help because of its inhibiting effect on the vagus nerve. Penicillin, aureomycin and other antibiotics are useful in treating the secondary infection which is usually present.

Gage⁴ has advocated the use of paravertebral sympathetic block for the relief of pain. It is felt that this procedure may also decrease spasm of the pancreatic vessels, and possibly may halt progression of the disease process. Orr and Warren⁸ have obtained good results using continuous epidural procaine analgesia.

Surgery is reserved for the late complications of abscess and pseudocyst formation. It is the consensus of most workers that operative intervention definitely increases the mortality in the acute stages of the disease.

TABLE VII
AMYLASE VALUES

- 17 Deter. Obt.
- 8 Deter. Obt. in first 24 H.
- 11 Deter. Obt. in first 48 H.
- 14 Deter. Obt. in first 72 H.
- 5 Elevations over 64 units

TABLE VIII
TREATMENT

- I. Medical
 - A. Relief of Pain
 - B. Naso-gastric suction
 - C. Withhold oral feedings
 - D. Fluids (Blood, plasma, and glucose)
 - E. Atropine, Banthine

- II. Surgical
 - A. Drainage of abscess
 - B. Drainage of pseudocyst

Conclusions

- (1) Acute pancreatitis is one of the most common causes of acute upper abdominal pain and the least recognized.
- (2) The attending staff and house officers should definitely become pancreatitis conscious by obtaining early blood amylase determinations.
- (3) Acute pancreatitis is one process which may regress or lead to abscess, cyst, and calcification of the pancreas.
- (4) Duct obstruction is the main factor in regard to etiology whether due to spasm, metaplasia of duct epithelium, or stone.
- (5) The Somogyi method for blood amylase (diastase) determination is quick, accurate and technically easy to perform.
- (6) The non-operative or medical therapy is the treatment of choice unless complications such as abscess, cyst or calcification develop.

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The Local Injection of Hydrocortisone in the Treatment of the Painful Joint

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IN THE MANAGEMENT of the patient with arthritis, not only must the general systemic disease be treated but attention must be directed toward relief of the pain and inflammation of the specifically involved joints. The usual methods of temporary splinting, local application of heat or cold, orthopedic manipulation and exercises have only limited beneficial effects, chiefly because local inflammatory symptoms persist. Shortly after discovery of the anti-rheumatic effects of cortisone, Thorn¹ reported definite anti-inflammatory effects following injection of Kendall's Compound F into the joint of a patient with arthritis. Hollander and associates,^{2,3} who have probably had the widest experience with intra-articular injection of hydrocortisone, have been enthusiastic about its adjunctive value. By reducing the inflammatory swelling and relieving the articular pain, this drug has greatly facilitated the general management of patients with certain types of arthritis. The mode of action of hydrocortisone in relieving the inflammatory symptoms is not yet understood.

The most impressive benefits of intra-articular injection of hydrocortisone have been obtained in (1) the rehabilitation programs of patients with rheumatoid arthritis with involvement of only one or two peripheral joints in whom the generally approved methods of treatment have been unsuccessful; (2) selected patients with gout in whom conventional methods of treatment are contra-indicated; (3) patients with symptomatic osteoarthritis who have failed to respond to simpler measures and (4) patients with bursitis. This

simple measure has also been observed to facilitate the rehabilitation program in patients for whom orthopedic procedures in one or several joints are indicated.

Material

This communication is concerned with the results of the intra-articular injection of hydrocortisone in 105 patients with various types of arthritis. The distribution of cases according to type is shown in Table I.

There were 61 females and 44 males ranging in age from nine to 77 years. The number of injections in any one involved joint varied from one to as many as ten.

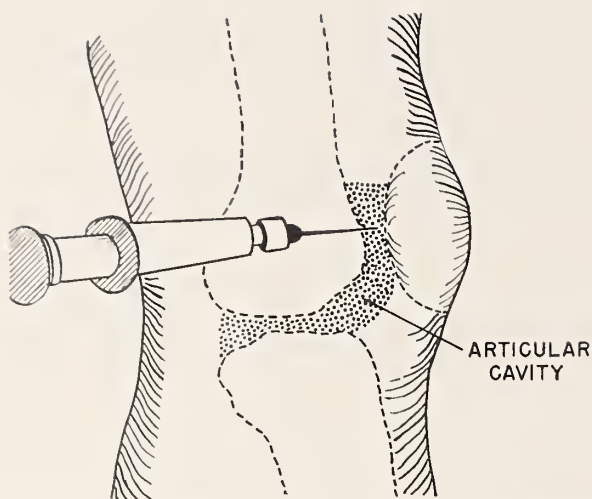
The injections were performed under aseptic conditions in the hospital, office or home. The skin was shaved and cleansed with an antiseptic solution and the area draped with sterile towels. The importance of the aseptic technic cannot be too strongly emphasized, as introduction of infection into these already inflamed joints would obviously be a major disaster. In most of our patients procaine was employed as a local anesthetic, but it was our impression from a study of those cases in which no anesthetic was employed that the relief obtained was produced by the hydrocortisone and not the anesthetic agent.

In most patients with rheumatoid arthritis, osteoarthritis, traumatic arthritis and gout, the knee joint was the site of injection. The ankle joint, interphalangeal joints and wrists can also be readily injected. The hip joint is more difficult to inject and the results are not as satisfactory as in the knee.

The average amount of hydrocortisone injected into the knee is from 25 to 50 mg. (1-2 cc.). The wrist joint requires a smaller amount and as little as 12.5 mg. may be used for the interphalangeal joints. In the presence of an abnormal

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Site of intra-articular injection of hydrocortisone into the knee.

amount of fluid it seems best to aspirate the fluid before injecting the hydrocortisone. For 24 hours after injection only moderate activity should be permitted.

TABLE I

Distribution of Patients with Painful Joints Treated by Intra-articular Injections of Hydrocortisone

Disease	Cases
Osteoarthritis	57
Rheumatoid arthritis	12
Noncalcified bursitis	10
Traumatic arthritis	8
Combined rheumatoid osteo-arthritis	7
Calcific bursitis	4
Gouty arthritis	4
Osteochondritis of knee	2
Localized arthritis of knee in patient with acute disseminated lupus erythematosus	1
Total	105

Results

Osteo-arthritis: All but two of the 57 patients with osteo-arthritis showed subjective improvement ranging from slight to considerable. It is difficult to evaluate subjective improvement but in at least half of the patients objective improvement also resulted. This was evidenced by the disappearance of local heat and swelling and measurable increase in range of motion. About 28 patients experienced relief of pain immediately after completion of the injection; this freedom from pain lasted from three days to 16 months. In other cases relief from pain was not obtained until 24 to 72 hours following injection. An occasional patient reported increasing improvement for several weeks; this may be attributed to the fact that the initial relief from pain enabled such patients to correct faulty walking habits, which in turn resulted in continued improvement.

The immediate response to the injection does not seem to have any relationship to the duration

of relief. It apparently is not possible to predict which patients will obtain relief or how long this will last. Approximately one-half of those with osteo-arthritis obtained some benefit for approximately three months following injection. Several patients reported that the injected joint remained comfortable for as long as 16 months.

Rheumatoid Arthritis: The response of this group to injection was not as favorable as that of the preceding group. Four of the 12 patients in this group obtained no relief and the remainder obtained slight or moderate relief seldom lasting more than three or four weeks. The temporary relief was marked by less pain, swelling, redness and tenderness of the injected joint.

Osteo-arthritis and Rheumatoid Arthritis: Six of the seven patients in this group obtained some relief but in general the degree of relief was not as great nor the duration as long as in the patients with osteo-arthritis alone. One of these patients reported pronounced relief of pain and swelling and increase in motion for four to eight weeks following each injection of hydrocortisone in the knee. This patient was able to be fairly active with injections in both knees at intervals of six to eight weeks for ten injections until he died of an unrelated illness. One patient in this group failed to obtain any relief.

Gout: Two of the four patients with acute gout obtained good results following injection and in one of these it helped the patient to overcome an acute attack of podagra during a period when a gastric ulcer was active. In one patient a fair response followed two injections of hydrocortisone into an acute gouty joint. No response was obtained in the other patient.

Traumatic Arthritis: The intra-articular injection of hydrocortisone appeared to decrease the pain in some of these patients for one or two weeks until the symptoms produced by the trauma itself had subsided.

Bursitis: Varying degrees of relief followed injection of hydrocortisone into the subdeltoid bursa of ten patients with noncalcified bursitis. In those with calcified bursitis the results were not spectacular. Sometimes immediate benefit was obtained, but the duration might be long or only brief.

Acute Disseminated Lupus Erythematosus: Relief of severe pain in the knee for 19 days was obtained in the one patient treated by intra-articular injection of hydrocortisone.

Comment

From this experience with the use of hydrocortisone it is our impression that it is a useful adjunct in the treatment of joints involved with osteo-arthritis, rheumatoid arthritis, traumatic arthritis, gouty arthritis, tendinitis or bursitis. Other conditions of the joints, such as epicondylitis at the elbow, may also respond favorably to local injection of hydrocortisone in the painful state when oral medication is contraindicated. Also, painful joints in a patient with a serious systemic illness, such as acute disseminated lupus erythematosus, may be made comfortable for a temporary period by the intra-articular injection of hydrocortisone. Advisability of repeated injections in a given patient depends upon the duration and degree of improvement. Injection every two or three days does not seem logical. If a significant amount of comfort is obtained for as long as three or four weeks after an injection, there may be certain circumstances under which periodic injections of isolated joints would be indicated. On the other hand, if an injection produces relief for several months, continuation of periodic injections would seem justified. If benefit is not noted after the initial injection, it is advisable to repeat the injection at least once before discarding this form of therapy.

In none of the 105 patients in whom this adjunctive method was employed did any complications of the injection develop. In those patients who received no benefit, the injection caused no untoward reactions.

It should be realized that hydrocortisone is injected into the joints not to treat the systemic disease but adjunctively to treat localized mani-

festations of the pathologic process. Therefore, it should always be used in conjunction with a well planned program of treatment usually consisting of adequate rest, physical therapy and general supportive measures. Cortisone, salicylates or gold salts may be used at the same time that hydrocortisone is being utilized. Hydrocortisone often restores comfort to a painful joint, but unless it is realized that the surrounding musculature may have atrophied and added to the loss of stability of the joint and the patient is treated accordingly, a poor therapeutic result is inevitable. Painful knees are usually associated with weak legs and thighs. The use of hydrocortisone will often relieve the discomfort in the knee but will not build up the atrophied muscles. Consequently, as soon as pain in the joints is relieved, it is important to introduce muscle rehabilitating exercises.

Summary

The intra-articular injection of hydrocortisone has been found to relieve pain and inflammatory symptoms for varying periods of time in a variety of types of arthritis and allied conditions. It is our clinical impression that it is a valuable adjunctive measure to other basic approved methods of therapy.

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The National Birth Rate

The national birth total in the first four months of 1954 topped the same period of 1953 by about 30,000, according to vital statistics estimates released today by the Public Health Service of the Department of Health, Education, and Welfare.

But marriages this year have continued to fall, after sinking in 1953 to 9.7 marriages per thousand and population, the lowest annual rate since 1933. Compared with the first four months of 1953,

marriages in the same period this year dropped by 25,000. The marriage rate for the period fell by 7.2 per cent.

The level of births for the first third of 1954 is running at a slightly higher annual rate than for the first third of last year. Total registered and unregistered births in 1953, estimated at 3,971,000, broke all previous records. This gave a rate of 25.1 births per thousand population, one of the highest in many years.

Weil's Disease in Georgia

A Report of Nine Human Cases

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PRIOR TO 1937 ONLY 14 authentic human cases of Weil's disease were reported from the United States and Canada. From 1937 to 1940, 40 additional human cases of Weil's disease were diagnosed by Packchanian (1938, 1941); these cases occurred in the following states: Connecticut, Louisiana, Maryland, Massachusetts, Michigan, Missouri, Nevada, New Jersey, New York, Ohio, Pennsylvania, Virginia and West Virginia, and in the District of Columbia.

In Georgia, no cases of Weil's disease, as far as can be ascertained, were reported prior to 1941, in which year one case was mentioned by Larson. Later, in 1945, seven cases were reported from the same state, by Sheldon.

The object of the present communication is to report nine additional human cases of Weil's disease from the state of Georgia, which were diagnosed by agglutination tests by the writer during the years 1946 to 1950.

Material and Methods

Samples of blood taken from several human cases of suspected Weil's disease were sent directly by attending physicians, or through the Medical School of Emory University, to the writer at Galveston, Texas, for the diagnosis of Weil's disease.

Schueffner's microscopic agglutination test for diagnosis of Weil's disease, as described in a previous communication, was used in this study (Packchanian, 1941).

The agglutination tests in this group were performed with Type I *Leptospira icterohaemorrhagiae*. Both positive and negative diagnoses are based on the degree of agglutination and the titre. The serum samples from the cases reported which gave clear-cut agglutination reactions within six

hours with a titre ranging from 1:1000 to 1:30,000 were considered positive (see Table I). Those cases which gave low or partial agglutination in titres 1:100 or below were considered doubtful or negative and are omitted from the present report.

Since all blood samples were collected at a later stage of the disease, and because of delay in transit, no animal inoculation or cultural tests were performed on any of these samples. The laboratory diagnosis is, therefore, based exclusively on agglutination tests.

Experimental Data

The results of this study are summarized in Table I.

Clinically, all patients had malaise, initial chill, fever, headache, muscular pain, nausea, vomiting and jaundice. Cases number five and number six showed a hemorrhagic tendency with the presence of petechiae, subconjunctival hemorrhages, retinal hemorrhages and hematemesis. Laboratory reports of the patients revealed an increase in total leucocytes, increase in serum bilirubin, decreased liver function and, in case number eight, a rise in the blood NPN.

The agglutination reaction of the serum from all these patients was complete within six hours and was clear-cut and diagnostic for Weil's disease. The blood sera collected from cases number one, two, four, five, six and seven showed a rise in agglutination titre from the first sample collected to the second sample, after an interval of one day up to two weeks, indicating a current infection. Cases number five, six, eight and nine received penicillin with no apparent effect on the course of the disease. Case number nine received streptomycin in addition to the penicillin but no curative effects were noted.

One of the noteworthy features is the similarity of occupation engaged in by the patients prior to onset of the disease (see Table I). All of these occupations, such as garbage collector, dairy worker, mechanic, poultry worker, etc., were conducive to skin abrasions and possible contact with infected rats and dogs.

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*This study was supported by contract between the University of Texas and the office of Naval Research of the U. S. Navy.

The writer wishes to express his thanks to the attending physicians (see Table I) and Dr. Mildred Marshall for their interest and cooperation in this study.

TABLE I

NINE HUMAN CASES OF WEIL'S DISEASE IN GEORGIA DIAGNOSED BY AGGLUTINATION TEST WITH TYPE I *LEPTOSPIRA ICTEROHAEMORRHAGIAE*

Patient No.	Attending Physician	Patient				Date of Onset	Agglutination Reaction		Outcome
		Age	Sex	Race	Occupation		No. Days Following Onset	Agglutination Titre	
1	Dr. W. F. Friedewald Emory University, Ga.	47	M	C	Garbage Collector	5-15-46	22 23	1:1,000 1:3,000	Recovered
2	Dr. Elizabeth O. King Emory University, Ga.	Adult	M	W	Physician	8-17-46	8 17	1:1,000 1:30,000	Recovered
3	Dr. W. F. Friedewald Mrs. Betty Jo Hunter Emory University, Ga.	Adult	M		Dairy Worker	9-12-46	22	1:3,000	Recovered
4	Dr. W. F. Friedewald Emory University, Ga.	Adult	M			10-8-46	6 12	1:100 1:1,000	Recovered
5	Dr. M. V. Murphy Dr. Harold Sutker Lawson VA Hosp., Ga.	24	M	W	Mechanic	8-19-47	8 15	1:100 1:10,000	Recovered
6	Dr. M. V. Murphy Dr. Dorothy N. Sage Lawson VA Hosp., Ga.	27	M	W	Mechanic	8-20-47	7 14	1:100 1:30,000	Recovered
7	Dr. W. F. Friedewald Emory University, Ga.	7	M	C	School Child	8-20-47	3 15	1:1,000 1:10,000	Recovered
8	Dr. Lee N. Foster Lawson VA Hosp., Ga. Dr. Richard France Dr. E. J. Van Slyck Dr. W. C. Williams VA Hospital, Nashville	73	M	W	Groceryman & Caretaker	9-11-47	54	1:30,000	Recovered
9	Dr. C. Merrill Whorton Lawson VA Hosp., Ga.	24	M	C	Poultry Market Worker	7-1-50		1:1,000	Recovered

Discussion

It has become increasingly evident that Weil's disease is common throughout the world and that, possibly, many cases have occurred in the United States which were, in the past, incorrectly diagnosed. A greater number of cases of Weil's disease can be revealed and readily differentiated from other diseases if proper laboratory methods now available are utilized.

It is well known that rats all over the world are carriers of *Leptospira icterohaemorrhagiae*. Examinations by the writer and his co-worker of various groups of rats (*Rattus norvegicus*) in several states throughout the country, indicated that between 10 and 25 per cent of rats were carriers of *Leptospira* (Packchanian and Sonnier, 1948). Occasionally an infected rat is killed by a dog which may subsequently contract the disease. Since *Leptospira* are excreted in the dog's urine, this animal also becomes a potential source of infection to children and adults (Packchanian, 1942, 1951).

Recent reports from the United States and other parts of the world have disclosed the incidence of leptospirosis (Weil's disease) in cattle (Beeson 1951, Gsell 1946). How cattle contract this disease, and whether they transmit the infection to other animals and to man, is not yet

known. During the last two years the writer has found antibodies for Type II *Leptospira* in the serum samples of several cattle from Arkansas, Oklahoma, and Texas (Packchanian, unpublished data).

Frequently an incorrect diagnosis of Weil's disease is made confusing it with infectious hepatitis (catarrhal jaundice). Due to the occurrence of these diseases in various degrees of severity and mildness and the misleading similarity of the clinical features, it is easy to confuse one disease with the other, particularly when proper laboratory procedures are not utilized and when the diagnosis is based chiefly on the clinical findings.

Weil's disease occurs sporadically and may be looked upon as an occupational disease; persons who have abrasions of the skin and who come in contact with the urine of rats or dogs are apt to contract this disease.

The absolute diagnosis of Weil's disease can be established only by specific laboratory methods. These consist of (1) direct microscopic demonstration of *Leptospira* in the blood or urine (a very difficult task), (2) guinea pig or deer mouse (*Peromyscus maniculatus gambeli*) inoculation with blood or urine or both, (3) culture of *Leptospira* from the blood or urine specimens of the patient, (4) serologic reactions, (5) demon-

stration of the *Leptospira* microscopically in stain sections of the viscera of cases terminating fatally.

Guinea pigs and deer mice (*Peromyscus m. gambeli*, *P. californicus* and *P. eremicus*) are highly susceptible to virulent *Leptospira*. These animals should be inoculated with the patient's blood at the onset of illness and with the urine of the patient from the second week to the fourth week afterward (Packchanian 1940, 1942).

The serologic tests should be performed with several types of *Leptospira* with patient's serum collected at various intervals during the course of the illness (Packchanian 1938). Agglutinins appear in the patient's circulating blood in sufficient concentration to be detected at the end of the first week of the disease; the titre usually rises to as high as 1:30,000 during the progress of the disease.

In order to demonstrate the possible use of agglutinin titre as indicative of current infection, it is important to test at least two samples, one taken during the first week of illness, and the second sample, 10 to 15 days following the first sample.

After the recovery of the patient from Weil's disease, the agglutinins remain in the circulating blood in sufficient titre from several months to as long as 20 years following complete recovery, making retrospective diagnosis possible in these cases (Packchanian and Tom, 1943).

Whenever the disease terminates fatally, sections of liver and kidney should be made and stained with Warthin's or Levaditi stain in order to demonstrate *Leptospira* within the cellular space (Ashburn and Packchanian, 1941).

Fresh autopsy material should also be inoculated into susceptible animals in order to establish absolute diagnosis.

Summary

1. Nine cases of Weil's disease have been diagnosed in the state of Georgia by agglutination tests. Five patients showed definite rise of agglutinin titre during their illness. All patients recovered with no apparent after effects.

2. The essential laboratory methods of diagnosis of Weil's disease are outlined and the epidemiology discussed.

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Defense Stockpile in Carrollton

The Federal Government has stocked a warehouse in Carrollton with medical supplies worth more than \$3,640,000 to be used only in the event of enemy attack on the United States.

The Carrollton stockpile is one of four in the U. S. The Federal Civil Defense Medical Director John M. Whitney states that within five hours, emergency medical equipment could be rushed to any of the five critical target cities in the Southeast which include Atlanta, Birmingham, Memphis, Chattanooga, and Knoxville. Whitney, who supervised the accumulation of the medical stockpile, emphasized that

it will provide only auxiliary help to a stricken community.

DeKalb County Civil Defense leaders are planning a 232-man master first aid station that would become a model for other such operations in the state. W. K. Sharpe, liaison officer between the state health department and the Medical Association of Georgia; Edgar Dunstan, chairman of the MAG committee on civil preparedness, and Lester Petrie, of the state health department are working with the DeKalb CD director in the planning stages of the proposed unit.



Denham, S. W. and Foraker, A. G., Emory University School of Medicine. "Cell Growth and Dehydrogenase Activity: a Histochemical Enzyme Study of Primary Squamous-cell Carcinoma of Bartholin's Gland," *Am. J. Obst. & Gynec.* 67:1151-1154 (May) 1954.

The histochemical standing reaction in a case of primary squamous cell carcinoma of Bartholin's gland is presented. The studies on the presently reported case were of particular interest in comparison with the histochemical studies on the far more common and clinically important squamous-cell carcinoma of the cervix.

This case fulfilled Honan's criteria in that: (a) it occurred in Bartholin's gland, (b) it arose deep in the labium, (c) it was in connection with the gland duct, and (d) it lay in apposition to Bartholin's gland tissue. Further, the skin was intact over the growth. Treatment consisted of a wide Bassett type bilateral groin dissection and vulvectomy.

Histochemical staining reactions were those of a fairly well-differentiated squamous cell carcinoma. Small amounts of glycogen were demonstrated in the tumor cells, increasing with cell maturation. The failure of intraepithelial cervical carcinoma to reveal histochemical glycogen-staining reactions is well known. Dehydrogenase activity was found in the neoplastic cells, decreasing with cell maturation. Paucity of glycogen deposition, increasing with cell maturity; and dehydrogenase activity increasing with cell immaturity should also apply to squamous-cell carcinoma of the cervix.

Equen, Murdock; Roach, George; Brown, Robert; Bennett, Truett, 144 Ponce de Leon Ave., N.E., Atlanta. "The Value of the Fluoroscope in the Removal of Foreign Bodies from the Air Passages, the Esophagus, Stomach and Duodenum," *Sou. Med. J.* 47:437-440 (May) 1954.

When it is suspected that a radiopaque foreign body has been aspirated or swallowed, one should by x-ray determine if it is within and, if so, where. If magnetic, the simplest way to retrieve it is by the use of the Equen magnet, under fluoroscopic guidance. If in the airways or food passages, its location should be checked before the scope of choice is inserted.

One of the most frequent objects to be swallowed by small children is the safety pin. Such a pin always goes down, spring first with the point up. With a magnet, the pin should be led into the stomach, there reversed under the fluoroscope, and then brought back up, the point harmlessly trailing. When a ferrous object is already in the stomach, the child swallows a magnet attached to an opaque string, and when the fluoroscope shows that the contact has been established, it may be recovered. Even when such an object has passed the pylorus, though it takes longer to establish contact, the foreign body can usually, under fluoroscopic guidance, be brought back up the natural channels without section of the abdominal wall.

Technical details of several cases illustrated with x-ray plates were presented.

Flynn, Gregory E. and Raiford, Morgan, Atlanta. "Beryllium and Delayed Corneal Healing. Report of a Case" *AMA Archives of Ophthalmology.* 51:89-91 (Jan.) 1954.

Over two months delay in healing of the cornea occurred in a patient after removal of a small particle of glass from a fluorescent lamp. Cortisone had no observable effect on healing. The absence of similar case reports in the literature prompted this one.

Haedicke, Thomas A., Atlanta. "Diagnosis and Management of Epidemic Hemorrhagic Fever," *Am. Practitioner and Digest of Treatment* 5:376-379 (May) 1954.

Epidemic hemorrhagic fever occurred for the first time in United Nations Troops during the Spring of 1951 while stationed in Korea. This disease was previously described by the Japanese in Manchuria beginning in 1939 and the Russians in Siberia. The etiology of this disease remains unknown but a virus or rickettsia is suspected. The pathophysiology of this disease includes generalized toxemia, severe capillary damage and hemorrhagic diatheses. Characteristic pathologic features consist of hemorrhage, necrosis

and infiltration with mononuclear cells of specific organs. The clinical picture is conveniently divided into febrile, reaction and convalescent periods. Albuminuria, leukemoid leukocytosis, oliguria and decreased specific gravity of the urine are invariably present and are most helpful in making the diagnosis. The diagnosis is made by correlating the epidemiologic data, clinical picture and laboratory findings. The treatment of this disease consists of rest, limitation of fluids, sedation and other supportive measures. No specific therapeutic agent has proven itself effective in altering the clinical course. Recovery is usually complete without any residuals but there is a mortality of four per cent.

Hill, Haywood N., 384 Peachtree St., N.E., Atlanta. "The Clinical Manifestations and Course of Aortic Stenosis," *Bull. Fulton Co. Med. Soc.* 28:23, 25, 46-47 (May) 1954.

This report summarizes data on 65 cases of aortic stenosis, 45 of them proved by autopsy, and 20 by the finding of calcified aortic valves.

It was found that the symptoms of congestive failure were usually most prominent, and that angina pectoris and sudden death were much less common than generally believed.

The anacrotic pulse, the narrow pulse pressure and the loud harsh aortic systolic murmur were found to be significant when present but their absence did not rule out aortic stenosis. This was also true of thrills and of the absence of the aortic second sound.

The electrocardiograms were not characteristic of the condition. Concentric cardiac enlargement and calcified valves were the only significant radiographic findings.

The course of the disease was found to be very variable with no really characteristic pattern. At autopsy all of the hearts were enlarged and heavy. The percentage of ante-mortem diagnoses was very low. It was felt that if this condition were to be diagnosed accurately, a more careful study, including fluorography, must be made on all cardiac patients.

Jeffery, Geoffrey M. and Eyles, Don E., Box 356, Milledgeville, Ga. "The Duration in the Human Host of Infections with a Panama Strain of *Plasmodium falciparum*," *Am. J. Trop. Med. & Hyg.* 3:219-224 (March) 1954.

Infections of a Panama strain of *Plasmodium falciparum*, induced in patients as treatment for neurosyphilis, were studied for duration of inadequately treated parasitemias. In 23 cases the infections persisted for an average of 279.5 days, with a range in duration from 114 to 503 days. There was little difference between blood and sporozoite induced infections where duration was concerned. The application of these findings to certain field conditions is discussed.

Among the differences noted between the Panama and U. S. strains were the more severe clinical attack and the longer duration of parasitemias in the former.

Kartman, Leo, Communicable Disease Center, U. S. Public Health Service, Atlanta. "Suggestions concerning an Index of Experimental Filaria Infection in Mosquitoes," *Am. J. Trop. Med. & Hyg.* 3:329-337 (March) 1954.

The need for a more adequate index of experimental infection in laboratory studies of mosquito hosts and filarial parasites is noted.

The concept of host efficiency is discussed and it is suggested that recent attempts to combine into a single formula an evaluation of early as well as late host-parasite relations render the host efficiency ratio less useful as a numerical symbol. Accordingly, an expression for host efficiency is proposed as a ratio of the mean number of third stage larvae per mosquito surviving at the termination of the filarial incubation period to the mean number of microfilariae per mosquito in samples shortly after feeding upon an infected vertebrate host.

Two additional components are suggested as follows: 1) the survival rate of the host, defined as the percentage of engorged female mosquitoes surviving the period of extrinsic incubation of the parasite; and 2) the infection rate of the host, derived by dividing the number of mosquitoes with third stage larvae at the termination of the parasite's incubation period by the number of surviving mosquitoes at the

end of incubation.

It is suggested that the appropriate effects of the above three components may be reflected by an index relating them in the following manner:

Index of experimental infection = (survival rate) X (infection rate) X (efficiency ratio)

The above formula is applied to experiments comparing the susceptibility of various species of mosquitoes to *Dirofilaria immitis*. On this basis, it is suggested that the present index, although subject to certain limitations, appears to be of practical value insofar as it succeeds in evaluating simultaneously certain factors which already have been demonstrated to affect the likelihood that a given species of mosquito will be a good host for a filarial parasite.

Leigh, Ted F. and Rogers, J. V., Jr., Emory University School of Medicine. "Anterior Sacral Meningocele," *Am. J. Roentgenology, Radium Therapy and Nuclear Medicine* 71:808-812 (May) 1954.

The authors present four cases in which a meningocele arises from the inferior end of the sacrum, and presents anteriorly in the pelvic cavity as a mass. These meningoceles may reach large size, filling the entire pelvis and displacing the adjacent organs. Women who are still in the child-bearing period may develop complications during labor by mechanical interference of the mass.

These meningoceles often communicate with the spinal canal. Surgical removal may lead to meningitis, unless adequate therapy is given. Before antibiotics practically all of these patients died.

Roentgenographically, the meningoceles produce a characteristic sickle-shaped deformity of the distal sacrum and coccyx. The soft tissue mass of the meningocele can often be seen in the pelvis.

Olansky, Sidney and Janney, J. M., Chamblee, Ga. "Vitamin 'B' Complex for Skin and Mucous Membrane Reactions To Chloramphenicol," *Arch. Dermatology & Syphilology*, 69: May 1954.

Patients receiving wide spectrum antibiotics, such as chloramphenicol, frequently develop lesions of the mucous membranes and adjacent skin which clinically resemble a Vitamin "B" deficiency.

A study was designed to attempt to demonstrate the effect of intramuscular Vitamin "B" Complex in the prevention and treatment of these reactions. Each alternate patient receiving chloramphenicol was given 1cc. of Vitamin "B" Complex, daily. In no instance did a reaction occur in the group receiving Vitamin "B" Complex. Six reactions occurred of 34 patients in the group receiving chloramphenicol, alone. As soon as reactions occurred, these patients were also given Vitamin "B" Complex daily. In all of these, improvement occurred with the administration of Vitamin "B" Complex in spite of continuance of chloramphenicol therapy.

Olansky, Sidney and Jennings, Paul B., Chamblee, Ga. "The Use of Procaine Amide in the Treatment and Prevention of Penicillin Reactions," *Ann. Int. Med.* 40:711-720 (April) 1954.

Two comparable groups of patients with allergic reactions to penicillin were treated with procaine amide (Pronestyl) and beta-ethyl-benzhydryl (Benadryl), respectively. The results in this study suggest that Pronestyl is probably superior to Benadryl in the treatment of these reactions.

Procaine amide was also used in an attempt to prevent reactions in known penicillin reactors. Prophylaxis was apparently successful in 13 of 18 patients.

No untoward reactions to procaine amide were noted.

Procaine amide is not the answer to the treatment of penicillin reactions but seems to be a useful drug in the management of some of them. The results of this study suggest that further clinical trial in the use of this drug in the treatment of, and prevention of, penicillin reactions is warranted.

Pratt, Harry D. and Good, Newell E., Communicable Disease Center, U. S. Public Health Service, Atlanta. "Distribution of Some Common Domestic Rat Ectoparasites in the U. S.," *J. Parasitol.* 40:113-129 (April) 1954.

The paper includes a brief discussion of the increase in murine typhus to a peak of some 5401 cases in 1944, and the remarkable decrease due to ectoparasite control to 186

cases in 1952. There is a graph showing total cases from 1941 to 1952 and a map showing distribution of cases of murine typhus in the United States. There follows a brief discussion of the rat ectoparasites taken commonly on the joint Murine Typhus Control Program of the various State health departments and the Communicable Disease Center, namely, the following four flea (*Nosopsyllus fasciatus*), sticktight flea (*Echidnophaga gallinacea*), and the mouse flea (*Leptopsylla segnis*); two species of rat lice: the spiny rat louse (*Polyplax spinulosa*) and the tropical rat louse (*Hoplopleura oenomydis*); and five species of rat mites: the tropical rat mite (*Bdellonyssus bacoti*), the spiny rat mite (*Laelaps echidninus*), the common rodent mite (*Haemolaelaps glasgowi*), the domestic rat mite (*Laelaps mutalli*), and the house mouse mite (*Allodermanyssus sanguineus*), the last a proven vector of rickettsialpox. There are distribution maps for all eleven of these ectoparasites.

Robinson, Edwin J., Jr., Communicable Disease Center, U. S. Public Health Service, Atlanta. "Notes on the Occurrence and Biology of Filarial Nematodes in Southwestern Georgia," *J. Parasitol.* 40:138-147 (April) 1954.

A filarial species suitable for laboratory study was sought by means of a survey of filarial infections in southwestern Georgia vertebrates. Infections found among 1,237 animals of 117 species examined are tabulated.

Among birds, 234 of 1006 individuals were infected, and the majority of species were found infected if ten or more specimens were examined. Four of 16 mammalian species and none of 35 reptile and amphibian species were infected.

The microfilariae almost invariably were found in only the lungs, and experimental results indicate a strict nocturnal periodicity in the birds. Adult worms were difficult to find. Multiple infections, in individuals or species, were not uncommon. Immature birds were infected, so vectors are present in the spring. Crows and blue jays had the highest infection rates among the most easily collected animals, and were selected as experimental hosts.

None of the microfilariae were specifically identified, but it was apparent that there was a certain amount of host specificity, and in two instances family specificity.

Shea, P. C., Jr.; Robertson, R. L. and Elkin, D. C., Emory University School of Medicine. "An Effective Clinical Method for Determining Coagulation Time of Blood," *Surgery* 35:398-704 (May) 1954.

This report presents a method for determining the coagulation time of blood which the authors believe to be more effective clinically than previously reported ones. It requires only simple and readily available equipment and has been found to give uniform, consistent results on the same sample of blood when performed by different personnel under varying conditions. Such slight variations as occurred represented smaller percentile errors than those usually found with other methods.

In a group of 150 hospital patients without evidence of intravascular clotting, the mean coagulation time was found to be 22 minutes; in a second group of 26 patients with thrombosis or embolism, it was found to be 14 minutes. This variation between health and disease was considered very significant from the standpoint of drawing attention to the possibility of intravascular clotting or confirming it if suspected. In addition, it is noted that an increased rate of clotting time as determined by this method would influence both the heparin tolerance curve and the calculated dose of heparin in anticoagulant therapy.

Wager, H. E. and Calhoun, F. P., Emory University School of Medicine. "Torula Uveitis," *Tr. Am. Acad. Ophth.* 58:61-67 (Jan.-Feb.) 1954.

A case of Torula Endophthalmitis is reported in a forty year old white female concomitant with pregnancy and meningitis. Spinal fluid revealed the presence of cryptococcus neoformans by culture and smear. Two months later the left eye became inflamed, tender and showed an acute ophthalmitis. Because of pain associated with uncontrollable increased tension, the eye was enucleated. Pathological sections of the eye done at Grady Clay Memorial Eye Clinic showed the Torula to be present in the eye. No response was made to the antibiotics and patient died five months after onset.



doctor placement page

AVAILABLE PHYSICIANS

Albea, John M., M.D., Apt. 108, E. Wherry, Fort Campbell, Kentucky, age 29, married, Protestant, graduate Tulane Medical School, 1952, presently an Army Medical Officer, interested in general practice in Georgia, available August 1, 1954.

Berry, Reginald V., M.D., US Naval Air Facility, Pensacola, Florida, age 47, married, Protestant, graduate Yale Medical School, 1932, residency Duke University, North Carolina; U. S. Naval Medical Center, Maryland, interested in psychiatry and neurology in Georgia (clinic, assistant associate or institutional), available July-August 1954.

Coleman, Julian B., M.D., US Naval Air Facility, Weeksville, Elizabeth City, North Carolina, age 33, single, Protestant, graduate McGill University, 1952, priority 4, size of community not important, in clinic or as an assistant or associate, available July 15, 1954.

Fitz, Thomas E., M.D., 1053 Oakland Avenue, Rock Hill, South Carolina, age 32, married, 3 children, Presbyterian, graduate Duke University School of Medicine, 1949, specialty—internal medicine and cardiology presently in practice, wishes to relocate due to economic status, desires group or associate practice, available two or three weeks after location secured.

Hunter, Robert, M.D., Hartford Hospital, Hartford, Connecticut, age 32, married, Episcopal, graduate Columbia University College of Physicians and Surgeons, 1943, board eligible—ob-gyn, prefers small clinic or an association, available July 1, 1954.

Lamb, James W., M.D., 906 Monroe Street, Vicksburg, Mississippi, age 38, married, Baptist, graduate Tulane University School of Medicine, 1938, residency Kansas City General Hospital, 4 year fellowship in general surgery, priority 4, specialty—general surgery, available July 1, 1954.

Maxwell, George A., M.D., 818 Thayer Avenue, Silver Springs, Maryland, age 32, married, Presbyterian, graduate University of Maryland Medical School, 1944, residency Maryland General and St. Agnes Hospitals, passed Part I, American Board of Ob-Gyn, wishes to locate in a relatively small town where sailing is readily available, prefers associate, available anytime.

MacKavanagh, James L., M.D., 160 Marion Avenue, Marrick, L. I., New York, age 44, married, Roman Catholic, graduate Georgetown University Medical School, 1934, presently in general practice, wishes to relocate, priority 3, interested in general practice in Georgia, size of community not too important, available within two or three months after location is selected.

Taber, Richard P., M.D., Department of Pediatrics, University Hospital, Ann Arbor, Michigan, age 30, single, Presbyterian, graduate University of Rochester Medical School, 1948, residency Buffalo Children's Hospital, N. Y.; University Hospital, Michigan, priority 4, interested in pediatrics in Georgia, available July 1, 1954.

Allen, Raymond A., M.D., c/o Mayo Foundation, Rochester, Minn. Born November 6, 1921, Lyman, Utah, single, Mormon, graduate University of Louisville, 1946, assistant resident in pathology one year, New York City Hospital, Fellow in pathology three years, Mayo Foundation, interested in location in Georgia, available July, 1955.

Battle, William C., 1st Lt., USAF (MC), 6407th USAF Hospital, Fearncom Air Base, APO 323, c/o Postmaster, San Francisco, Calif. Graduate Duke Medical School, 1949, surgical internship at Duke 1949-50, Pediatric internship at Long Island College Hospital, 1951-52, Board eligible in pediatrics, plan to take exams this year, currently completing a tour as pediatrician at the 6407th USAF Hospital, Tachikawa, Japan. Available July, 1954.

Bragg, Rudolph, M.D., 567th Medical Squadron, McChord Air Force Base, Washington. Age 28, single, Methodist, graduate Medical College of Georgia, 1952, license held in Georgia, interested in general practice as an individual or associate, in community under 10,000 in Georgia. Available July 1, 1954.

Ganl, Jack H., M.D., Lafayette Charity Hospital, Lafayette, La., age 31, single, Episcopalian, graduate Louisiana State University Medical School, 1952, rotating residency, Lafayette Charity Hospital, interested in general practice, in clinic or as an associate, available July 15, 1954.

Garner, J. W., M.D., Crawfordville, Ga., currently engaged in general practice, age 26, married, one child, Baptist, graduate Medical College of Georgia, 1949, 1½ years general practice residency, Charity Hospital 2A Classification, interested in general practice in Georgia, 2,000 up.

Gray, Henry T., M.D., 9-C Copeley Hill, Charlottesville, Va.; will complete residency in dermatology and syphilology in June of this year, will be Board eligible, most interested in an association with another dermatologist or a group, would not be opposed to solo practice.

Kinzer, Gilbert M., Lt. MC USN, Main Dispensary, USNAS, Corpus Christi, Tex., 30 years of age, B.A. degree Vanderbilt University, M.D. degree University of Tennessee, 1947, have a basic science certificate and medical license, owned and operated a small hospital in Caraway, Ark. (GP-Surgery) took PG course in pediatrics at Harvard Postgraduate Medical School, called to active duty '51, graduated from School of Aviation Medicine, which gives special training in EENT, cardiology and physiology, desires to locate in South in a town with minimum 3,000 population, town must have hospital, plans to do general practice with obstetrics and limited major surgery, prefers an association with another doctor.

Moore, Melvin, M.D., 915 East 17th Street, Brooklyn, N. Y. Born January 5, 1924, married, Hebrew, graduate Chicago Medical School, 1946, certified by American Board of Radiology, residency, Newark Beth Israel Hospital, Queens General Hospital, specialty, Radiology, available March, 1954.

Lee, James Earl, M.D., Flower and 5th Avenue Hospital, Interns' Quarters, New

York 29, N. Y., age 33, married, Protestant, graduate New York Medical College, 1954, draft exempt by previous service, interested in general practice in Georgia, available July, 1955.

Moseley, Robert W., M.D., 97th General Hospital, APO 757, c/o Postmaster, New York, N. Y., age 28, married, Christian, graduate Medical College of Virginia, 1948, residency Walter Reed Army Hospital, Board eligible for pediatrics. Available July 1, 1954.

Pattison, John D., M.D., FASRON 104 Det. 1, FPO, New York, N. Y., age 34, married, Protestant, graduate University of Pittsburgh, 1944, residency VA Hospital, service completed October 5, 1954, specialty internal medicine, clinic or group practice in Georgia, available one or two months after discharge.

Rutledge, James W., M.D., The John Gaston Hospital, Memphis, Tenn., age 29, married, Protestant, graduate New York Medical College, FFAH 1953, priority 4, served 30 months in USAAF, completing rotating internship at University of Tennessee, interested in general practice in Georgia, available July, 1954.

Sakol, Marvin J., M.D., 233 Ridgedale, Louisville, Ky., interested in internal medicine and hematology, completes residency in internal medicine in July and is particularly well trained in hematology.

Schifflett, Joseph Ray, M.D., US Naval Hospital, Jacksonville, Fla., age 29, married, one child, Protestant, graduate Baylor University College of Medicine, 1953, priority 4, interested in general practice in Georgia, available August 1, 1954.

Segal, Milton, M.D., 675 Dickson Parkway, Mansfield, Ohio, 34 years of age, certified radiologist, interested in practice of radiology in office, hospital or group.

Shea, Wm. H. H., M.D., 568th USAF Dispensary, McGuire Air Force Base, Trenton, N. J., age 33, married, Roman Catholic, graduate University of Maryland, 1951, priority 4, interested in general practice, available July 15, 1954.

Stark, C. V., M.D., Box 109, Arcadia, Fla., wants practice in Georgia during spring of the year only, as he spends winters in Florida, born November 25, 1878, widower, graduate Oploma Medical University, Tenn., 1900, specialty—general medicine, population 1,000 or more.

McCree, Robert L., M.D., 504 Arey Ave., Albemarle, N. C., graduate of Meharry Medical College, 1946, two years residency—internal medicine, finished 3-year term in Army, since discharge have taken over practice of a classmate, who will return in August, 1954. Desires to establish himself in practice. Would like town with fairly large Negro population.

Bonner, Mack S., M.D., 133 Jackson Drive, Slocum Village, Havelock, N. C. Will be discharged from the Navy within next six to eight months; graduate Medical College of Georgia; licensed in Georgia; interested in general practice in which also might practice some anesthesia.

Brannon, R. A., Jr., M.D., Vicksburg Clinic, 1600 Monroe Street, Vicksburg, Miss. Interested in establishing practice in Dermatology and Allergy at Brunswick,

Georgia. Board eligible in Dermatology; had seven years experience as a health officer.

Ewing, George B., M.D., LaFargeville, New York. 50 years of age; married; Methodist; graduate Vanderbilt Medical School, 1929. Presently in practice, desires change of climate; Priority 4; interested in general practice in community of 1500 to 2000 in Georgia. Available early fall.

Lloyd, Thomas S., Jr., M.D., Southern Baptist Hospital, 2700 Napoleon Avenue, New Orleans 15, Louisiana. Age 28; married, two children; Presbyterian; graduate Medical College of Virginia, 1948; priority 4; completing 3rd year residency of Ob-Gyn at Southern Baptist Hospital; available January 1, 1955.

McCorkle, Robert G., Jr., M.D., 350 South Fuller 4J, Los Angeles, Calif. Age 30; married; Catholic; graduate Baylor University School of Medicine, 1946; priority 4; specialty—Thoracic Surgery. Interested in association with another doctor. Available August 1, 1954.

Moseley, Charles H., M.D., 707 Duncan Avenue, Killeen, Texas. Graduate Medical College of Georgia, 1952. Desires to become associated with a competent general surgeon to assist in surgery and do general practice. Available July 1, 1954.

Psimas, James M., M.D., M.O.Q. H-2, Cherry Point, North Carolina. Age 30, married, two children, Episcopal, graduate University of Virginia, 1948. Residency N. C. Baptist Hospital; St. Luke's Hospital, and DePaul Hospital. Specialty—Ob-Gyn only. Group preferred. Available September, 1954.

Schneider, Chas. F., M.D., VA Center, Biloxi, Mississippi. Age 36, Married, Lutheran, graduate University of Virginia School of Medicine, 1943; certified by the American Board of Surgery; presently in practice, desires private type practice; priority 4. Specialty—general surgery. Available 60 to 90 days notice.

Hendrick, James Wesley, M.D., 7030 Cohn Street, New Orleans, Louisiana. Age 30, married, Methodist, graduate University of Tulane Medical School, 1949. Will be board eligible Ob-Gyn in July, 1954. Specialty—Ob-Gyn; prefers assistant or associate. Available July 1, 1954.

Ingram, William, Jr., M.D., U.S. Naval Hospital, Oakland, Calif. Age 32. Married, Protestant. Graduate of University of Georgia School of Medicine, 1946. Residency USNH, Philadelphia; St. Albans, N. Y.; Oakland, California. Specialty—Neuropsychiatry (Clinic or institutional). Available June, 1954.

Moore, George W. St. Clair, M.D., 101 Ardmoor Avenue, Danville, Pa. Age 29. Married. Protestant. Graduate of University of Pennsylvania, 1948. Residency Geisinger Memorial Hospital and Foss Clinic. Specialty—Urology. (Clinic, Assistant or Associate). Available July, 1955.

Pool, Winford H., Jr., M.D., 152 Longview Drive, Lafayette, Louisiana. Age 27. Married, two children. Baptist. Graduate Medical College of Georgia, 1952. Interested in General Practice in Georgia in community of 5,000 to 20,000 (private or associate). Available July, 1954.

Rogers, Charles S., M.D., 3739 Locust Street, Philadelphia 4, Pa. Age 30. Married; Presbyterian. Graduate University of Pennsylvania, 1947. Residency University of Pennsylvania Hospital. Priority 5-A. Specialty—Surgery (General and/or thoracic). Any size community. Available July 1, 1954.

Shanahan, John Rush, M.D., 10310 Greenfield Street, Kensington, Maryland. Age 39. Married; Roman Catholic. Graduate Georgetown University, 1948. Residency U. S. Naval Hospital, Bethesda, Maryland. Priority 5. Specialty—Internal Medicine. Desires community in Georgia of 20,000 to 30,000. Available June, 1955.

Newman, Harvey, M.D., US Naval Hospital, Beaufort, S. C. Age 28; married; Protestant; graduate Medical College of Georgia, 1948. Residency Children's Medical Center, Dallas, Texas. Specialty—pediatrics. Interested in community in Georgia as associate or assistant. Available August 1954.

Reichel, Hans A., M.D., 302 East Huntingdon Street, Savannah, Georgia. Interested in relocating in Georgia as an internist or in general practice or industrial medicine.

Woods, E. Ashby, M.D., Montevideo, Penn Laird, Virginia; graduate University of Virginia, 1952; age 30; married, interested in obtaining a position as either an assistant or in industrial practice in Georgia.

AVAILABLE LOCATIONS

Dawsonville, Georgia—(Dawson County) Have a modern well equipped health clinic. Arrangements for an office can be made without difficulty. No physician in county. (pop. 500) Contact: Mr. Carlton Gilleland, Mayor City of Dawsonville, Dawsonville, Georgia.

Doraville, Georgia (DeKalb County). Hospital in nearby Chamblee, small clinic in Doraville for rent. New homes being built \$8,950.00 up. Grammar-high school. Social and recreational facilities. Population sufficiently large enough to support physicians. (County pop. 30,900). Contact: Mr. George W. Walker, City Clerk, Doraville, Georgia.

....Villa Rica, Georgia (Carroll County) New 24 bed HB hospital to be built soon. Now have seven bed hospital. Office available for lease, reasonable. Housing available at reasonable cost. 12 grade accredited

school. (Pop. 3,200). Contact: Mr. Edgar P. Candler, Villa Rica, Georgia.

Buchanan, Georgia—(Haralson County) No physicians in area; 20 bed hospital, not in use, may be purchased at give away price. Housing available rent or buy reasonably. Need two doctors to run hospital or clinic, as they so desire. Contact: Mr. P. G. Camp, Buchanan, Ga.

Americus, Georgia—(Sumter County) Population 11,367, county population—24,208. About to be without a practicing Negro physician; two Negro schools with an enrollment of 1355; two hospitals, 140 beds, 19 doctors; housing available reasonably; Americus is a very prosperous community with a large number of business establishments. Contact: Mrs. Emma G. Anderson, 213 Forrest St., Americus, Georgia.

Cumming, Georgia—(Forsyth County). Located 40 miles north of Atlanta on U.S. Highway 19. Office and clinic building now vacant that can be fixed immediately to suit one or two doctors, either with clinic, hospital or office set-up. As president of the bank in Cumming, in position to help young doctor get started. Good churches, schools, city clubs and living conditions. Population 2,500, county 15,000. Contact: Mr. Roy P. Otwell, Cumming, Georgia.

Alma, Georgia—Bacon County—Present surgeon and general practitioner unable to handle all his practice. Would like to have another doctor as his partner. Has completely furnished offices including laboratory and x-ray. New 30-bed Hill Burton Hospital opened. Contact Dr. B. E. Daniel, Alma, Georgia.

Blackshear, Georgia—Pierce County— Opening for two physicians, new air conditioned completely modern clinic, fully equipped and located directly across street from new 25-bed Hill Burton Hospital. Established practice which will gross \$40,000 per year. No significant competition from other doctors. Housing available. Assume one year lease on clinic and notes on equipment, if desired other arrangements can be made. Contact: Dr. T. C. Nation, Box 68, Blackshear, Georgia.

Marietta, Georgia—Cobb County—Interested in Negro physician to replace present physician who is going into armed forces. Contact Mr. Millard L. Wear, Administrator; City of Marietta Hospital Authority; Kennestone Hospital, Marietta, Georgia.

Roberta, Georgia—Crawford County— No physician in area, county maintains a large home with most reasonable rental available for resident doctor. Plans for clinic nearing completion, immediate use of rooms in present clinic building, also three rooms over post office ready for use, year's rent free. Excellent opportunity for qualified physician looking for general practice. Contact Mr. J. Welborn Johnson, P. O. Box 143, Roberta, Georgia.



*Please Contact Headquarters Office
of the Medical Association of Georgia
875 W. Peachtree St., N. E., Atlanta, Georgia
When a Location Has Been Filled*

Journal Conference, Lake Burton,

May 30, 1954

On Sunday, May 30, 1954, a conference concerning the affairs of the *JMAG* was held at the Lake Burton cottage of George T. Nicholson, Cornelia.

The meeting was called to order by the conference chairman, Dr. Nicholson, at 10:30 a.m. Those present were Robert T. Jones, Canton; W. P. Stoner, Sylvester; Chris J. McLoughlin, Atlanta; Herbert S. Alden, Atlanta; Charles Hock, Augusta; Lester Rumble, Jr., Atlanta; David Henry Poer, Atlanta, *Journal* Editor; Edgar Woody, Jr., Atlanta, *Journal* Associate Editor; Alex B. Russell, Winder; Ted F. Leigh, Atlanta;

O. C. Pittman, Commerce; Arthur Merrill, Atlanta; W. Bruce Schaefer, Toccoa; Charles R. Andrews, Canton; Mrs. Ted F. Leigh, Atlanta; Mr. John F. Kiser and Miss Frances H. Porcher, of the *Journal* staff.

Dr. Nicholson called on Dr. Poer who explained that the meeting was called primarily to discuss the results of the *Journal* survey taken by Dr. Nicholson in the Ninth District. Dr. Poer stated that a state medical journal is first of all the archives of the Association. Secondly, it presents to the physicians scientific articles and special articles of interest to them. A medical journal



Seated left to right: Andrews, Russell, Nicholson, Poer, McLoughlin and Merrill. Standing: Schaefer, Stoner, Jones, Leigh, Hock, Pittman, Rumble, Woody and Alden.

does not have to be dull reading and the editor and staff have been striving to make the *Journal* of the MAG an attractive publication that is a pleasure to read.

Miss Porcher outlined the contents of an average issue of the *Journal*.

Dr. Nicholson then called on Dr. Woody to report on the system of having contributing editors appointed on a basis of geography and specialty. Dr. Woody stated that this policy has worked out very well and would be continued in the future with appointments being made yearly. The purpose of the Contributing Editors is not only to write for the *Journal* but to act as a board to reject or accept for publication all papers submitted. At least three people must pass on a paper before any definite action can be taken. It was decided that all papers must be submitted in triplicate henceforth in order to facilitate their disposition. Papers are to be judged on merit alone; Annual Session papers have no priority over unsolicited papers.

At this time Dr. Nicholson reported on the Ninth District Survey. Sixty-eight questionnaires were returned to Dr. Nicholson, or 80 per cent of the total sent out in the district. Sixty of these said that they read the *Journal* regularly; seven, seldom; one, never (he has not been receiving his *Journal* and we hope that is the only reason he has not read it).

As for the department most enjoyed, 21 said Editorials; 47, Scientific Articles; 12, Special Articles; 15, Association news; 25, Personals; seven, the Executive Secretary's Letter; three, Bookshelf; and four, Abstracts. Many of the doctors of the Ninth District said they would like to see some humor added to the *Journal*. Other criticism of editorial policy was expressed in certain dislike of whisky and cigarette ads in the *Journal*. The consensus of opinion of those attending the conference was that the publishing of such ads did not necessarily mean that the MAG endorses those products and the revenue elicited from them is necessary in the publication of the *Journal*. Also brought out was the fact that some doctors don't like advertising interspersed among the articles.

Fifty-five said that they did not want a larger *Journal*, 13 said they did. Twenty-six doctors read the *Journal* from one to five hours; 21, less than five hours; and one, more than five hours. Thirty-eight out of the 68 take the *Journal* home, 30 do not.

Some of the pertinent comments and suggestions were as follows:

1. Leave the ads out of the scientific section.
2. Leave out rare and unusual papers; direct the publication more or less in the direction of the general practitioner.
3. Include more statewide personal news.
4. Improve the quality of the scientific articles.
5. Add good humor in the form of footnotes, a column for doctor contribution or cartoons.
6. List officers, committees and committee activities.
7. Omit meeting dates of county societies; these are too often changed.
8. Include more up-to-date personal news.
9. Publish comments on new drugs.
10. Set up a department for answering questions of GP's.
11. Publish works of Georgia authors only.

It was felt that the Ninth District has a good cross section of the doctor population of Georgia as far as suburban and small urban areas is concerned. Dr. Russell suggested that perhaps to get the complete picture one of the large cities should conduct a similar survey. Augusta was suggested as a probable location and Dr. Hock was asked to look into the matter for future reference.

Mrs. Ted F. Leigh told the group assembled about the *Woman's Auxiliary News*, of which she is editor. Her publication has received national recognition. She explained the system of gathering news from all over the state through the county society auxiliaries. This system was suggested for the *JMAG*, i.e., have a reporter in each county or district responsible for sending in news.

Mr. John Kiser further stated that statewide coverage was needed and it was suggested that perhaps someone from the *Woman's Auxiliary* in each county would do the best job of reporting personal news.

Mr. Kiser also explained a new policy of the *Journal* concerning advertising. It is felt that this office should not have the final responsibility of deciding who should advertise with the *Journal*. In the future decisions concerning pharmaceutical advertising will be made by the AMA, and only council accepted products will be advertised.

Dr. Woody discussed "special issues". There was much favorable comment on the March Crawford W. Long Memorial issue of which Lester Rumble, Jr., was guest editor. It was an-

nounced that the September issue will be a special Emory issue commemorating the one hundredth anniversary of the medical school. Ted F. Leigh will be guest editor of the Emory issue.

It was suggested that there should be some special articles (not whole issues) of advice for the young doctor just entering practice as to ethics, equipment for the office, investments, etc.

Dr. Nicholson then called on Dr. Leigh, Journal Photographic Editor, to say something about the cover. Dr. Leigh expressed the hope that the covers have met with the approval of the readers. Dr. Nicholson expressed the feeling of the company present when he said how glad he was that the *Journal* no longer carries advertising on the cover. Dr. Leigh went on to say that the cover always ties in with the contents or season of the year to give it real meaning. The occasional

change of color for a special issue was heartily approved.

W. P. Stoner of Sylvester and Dr. Nicholson commented on the *JMAG* as seen by a general practitioner saying that they wanted the *Journal* to be practical, brief and readable. The *Journal* in the past three years has become a better publication with a good cover and more interesting and readable articles. Dr. Stoner suggested that average contents should consist of three articles directed toward the GP and one specialized article.

The conference was brought to a close after a summary of the results of the meeting and Dr. Poer expressed the thanks of all those present to Dr. and Mrs. Nicholson for opening their home to this group and for their genial hospitality.

The meeting was adjourned at 12:30 p.m.

MAG Council Meeting, Atlanta

June 5-6, 1954

A meeting of the Council of the Medical Association of Georgia held in the Academy of Medicine, Atlanta, was called to order at 7:30 p.m., June 5, 1954.

Council members present included: H. L. Cheves, Union Point, Chairman; H. Dawson Allen, Milledgeville; D. Lloyd Wood, Dalton; J. W. Chambers, LaGrange; George Dillinger, Thomasville; J. G. McDaniel, Atlanta; Clarence B. Palmer, Covington; Neal Yeomans, Waycross; Mark Dougherty, Atlanta; Charles Andrews, Canton.

Officers present included: Peter B. Wright, Augusta; David Henry Poer, Atlanta; Milford B. Hatcher, Macon, and H. Dawson Allen, Milledgeville.

Committee members and guests included: Eustace A. Allen, Atlanta; Tully T. Blalock, Atlanta; Duncan Shepard, Atlanta; Lester Rumble, Jr., Atlanta; B. F. Shackelford, Atlanta; Hoke Wammock, Augusta; J. C. Thoroughman, Atlanta; L. Minor Blackford, Atlanta; Helen Bellhouse, Atlanta; Edgar M. Dunstan, Atlanta; A. O. Linch, Atlanta; Robert Pendergrass, Americus; and Messrs. Milton D. Krueger and John F. Kiser.

The following committee reports were given

by committee chairmen to the MAG Council.

1. AUDIT AND APPROPRIATIONS COMMITTEE—J. W. Chambers, Chairman. Chambers discussed the budget item by item and gave in detail financial expense of the 1954 Annual Session in Macon.

Approved: The Report of the Audit and Appropriations Committee.

Recommended: On motion by Poer, seconded by Chambers, that Council seek the advice of the Honorary Advisory Board on the matter of the most desirable amount for a reserve fund for the purpose of running the Association in the event that no dues or other income is available. The motion carried.

2. REPORT OF THE MATERNAL AND INFANT WELFARE COMMITTEE—Helen Bellhouse, Secretary. Bellhouse discussed the North Carolina Plan for study of neonatal stillbirth and other forms of infant and maternal morbidity. Bellhouse also discussed the problems of Georgia on midwifery, and it was suggested that neonatal care might be included in the Georgia Plan of prepaid insurance.

Approved: The Report of the Maternal and

Infant Welfare Committee.

Recommended: On motion by Poer, seconded by Dougherty, that the Maternal and Infant Welfare Committee meet with the Committee on Legislation to discuss midwifery legislation and that the committee meet with the Insurance Board to consider the problem of neonatal care and its possible inclusion in the Georgia Plan. The motion carried.

3. INDUSTRIAL HEALTH COMMITTEE—Duncan Shepard, Chairman. Shepard discussed the Committee's concern of the payment of a maximum of \$750 for industrial injuries as presently covered by insurance policies now written. The Chairman stated that his committee was considering a possible division of the insurance companies payment between (1) medical and (2) hospital. Shepard also discussed the formation of a new subcommittee to be known as the Compensation Insurance Subcommittee.

Approved: The Report of the Industrial Health Committee.

4. CONSTITUTION AND BY-LAWS COMMITTEE—J. W. Chambers, Chairman. Chambers said that his committee will take all recommendations made by Council, House of Delegates and the various MAG Committees concerning changes in the present Constitution and By-Laws and revise them accordingly. Chambers also stated that his committee would go through the present Constitution and By-Laws word by word to clarify any confusion in the present wording.

Approved: The Report of the Constitution and By-Laws Committee.

5. THE COMMITTEE ON BLOOD BANKS—J. C. Thoroughman, Chairman. Problems to be worked out for 1954-55 by the Committee include setting up a minimum standard for blood banks so that blood bank officials may know what their banks must have to be accredited.

Recommended: Charles Andrews, Canton, recommended that the Committee on Blood Banks give further consideration to the matter of "walking blood banks" in counties that have no existing blood bank.

Approved: The Report of the Committee on Blood Banks.

6. PUBLIC RELATIONS COMMITTEE—Chris J. McLoughlin, Chairman. McLoughlin outlined the eight points that are to be stressed by his committee through the facilities of the headquarters office. These points include mediation committee, emergency call system, medical forums, press

spokesman, paramedical field activity, medical secretaries instruction course, etc.

Approved: The Report of the Public Relations Committee.

7. MEDICAL CIVIL PREPAREDNESS COMMITTEE—Edgar M. Dunstan, Chairman. Dunstan reviewed plans for committee work for 1954-55 and brought out that the committee was concerned for more physician education on medical services rendered by physicians during catastrophies.

Recommended: By general agreement that the headquarters office alert county medical societies to the importance of the organization of physician care and treatment in catastrophies.

Approved: The Medical Civil Preparedness Committee Report.

8. CHRONIC ILLNESS COMMITTEE—L. Minor Blackford, Chairman. Blackford stated that his committee will be concerned with the problems of instituting instruction at the Georgia medical schools in rehabilitation and he cited the need in Georgia for more physical therapists.

Approved: The Report of the Committee on Chronic Illness.

9. CRAWFORD W. LONG MEMORIAL COMMITTEE—Lester Rumble, Jr., Chairman. Rumble stated that the purpose of his committee will be to advise the State Historical Commission on the maintenance of the proposed C. W. Long Memorial Building at Jefferson, Georgia. He stated that this entails a small financial responsibility by the Association. He also emphasized the possible role of the Woman's Auxiliary to the MAG in promoting the project and further recommended that the House of Delegates appropriate each year a maximum of \$1,000.00 for the maintenance of the proposed shrine.

Rumble also discussed the Georgia Anesthetic Study Commission and gave members of Council copies of the plan for their study. He pointed out that the 1954 House of Delegates voted in favor of this plan and voted to set up a 12-member committee to work out the plan.

Approved: The Report of the Crawford W. Long Memorial Committee.

10. MEDICAL ADVISORY COMMITTEE TO SELECTIVE SERVICE—A. O. Linch, Chairman. Strickler submitted a written report and Linch amplified the plans and projects of this committee. It was brought out that physicians in Priority I will be called this year and that members of the Association should cooperate to get these men in service.

Approved: The Report of the Medical Advisory Committee to Selective Service.

Committees from which no report was received are as follows: Medical Education, Medical Defense, History and Vital Statistics, Cancer, and Abner Welborn Calhoun Lectureship.

11. A report was presented by Mr. Krueger, MAG Executive Secretary, concerning the present status of the headquarters office. Mr. Krueger stated that the reorganization of the filing system was being completed and that upon its completion a reorganization of the records and membership file would be undertaken. He also stated that the proposed travel plan by members of the headquarters office is now in force and that two to three medical societies would be visited weekly.

Approved: The status of the Headquarters Office.

12. Report on the 1954 Annual Session—Mr. Krueger. A complete report of the 1954 Annual Session was given Council by Mr. Krueger, MAG Executive Secretary. He stated that the Annual Session finances to date showed the Association was “in the black” and that this was a good indication of the success of the meeting as far as the physical arrangements were concerned. He also reported that a meeting of the 1954-55 Committee on Scientific Work and the 1954-55 Specialty Society Program Chairmen is scheduled to be held jointly on July 11 in Augusta. Mr. Krueger expressed the hope that all planning and programming for the 1955 Annual Session could be wound up by January 1, 1955.

Approved: The Report of the 1954 Annual Session.

A motion made to recess was duly seconded and approved; the Council meeting recessed at 10:30 p.m.

Following the over-night recess, the Council of the Medical Association of Georgia was called to order at 9:30 a.m. by Chairman Cheves in the Academy of Medicine, Atlanta, June 6, 1954.

Members present, who were not in attendance at the Saturday meeting, included: Lee Howard, Savannah, and W. G. Elliott, Cuthbert.

Committee Chairmen in attendance included: David R. Thomas, Jr., Augusta, and John L. Chandler, Jr., Augusta.

The invocation was read by Secretary-Treasurer David Henry Poer.

Items of business considered were as follows.

1. AMA-MAG Membership Status Clarification—Mr. Krueger. Council was asked to clarify

the present Constitution and By-Laws concerning Life Membership. Specifically, the Constitution and By-Laws merely states “. . . he shall not be subject to the payment of dues.” Mr. Krueger informed Council that in the past, Life Members have been granted all rights and privileges of the Association. Specifically, Mr. Krueger wanted clarification of whether this policy, which seemed to include (a) holding office and voting, (b) medical defense, and (c) receiving the MAG Journal free, should be continued. Mr. Krueger also asked that a special committee of Council be appointed to review AMA-MAG Membership classifications with a view to closer conformity in membership classifications between MAG and AMA.

Action Taken: On motion by Poer, seconded by Dillinger, Council voted to continue on a temporary basis the practice of giving all Life Members “all rights and privileges of the Association” which include (a) holding office and voting, (b) medical defense, and (c) receiving the MAG Journal free. Council also voted to set up a special committee of Council to study this question further and concurrently study the problem of AMA-MAG membership classification. The committee to be composed of Mark S. Dougherty, Chairman, Atlanta; W. G. Elliott, Cuthbert, and Neal Yeomans, Waycross. The motion carried.

2. INSURANCE BOARD—David R. Thomas, Chairman. Thomas discussed the problems faced by the Insurance Board and cited the following: (1) For Georgia Plan coverage married persons use aggregate income of wife and husband. (2) Eliminate certain few unfair practices by companies writing Georgia Plan policy. (3) Consider changes in Georgia Plan for a more complete medical care coverage. (4) Consider possibility of a state-wide Blue Shield plan. (5) Investigate insurance carriers policy on cancelling coverage for dubious reasons. Thomas asked that the Executive Committee of Council meet with the Insurance Board on July 11, 1954.

Action Taken: By general agreement, it was recommended that the Insurance Board investigate the Florida Blue Shield set-up and that the Executive Committee of Council meet with the Insurance Board on July 11.

Approved: The Report of the Insurance Board.

3. AMEF COMMITTEE—John L. Chandler, Chairman. Chandler outlined the following points as projects for 1954-55: (1) Acquaint Georgia physicians with the principles of AMEF. (2) En-

list Auxiliary aid to educate physicians on importance of AMEF. (3) Mail to all Association members a counter check with return envelope to stimulate contributions after items one and two have been completed.

Action Taken: On motion by Allen, seconded by Dougherty, that on the authority of Council a voluntary assessment of not less than \$10.00 for all Association members be effected and that statements be sent to all members. The motion carried.

Approved: The Report of the AMEF Committee.

4. COMMITTEE ON MENTAL HEALTH—J. R. Shannon Mays, Chairman. The Chairman outlined many projects for 1954-55 and these were essentially the same as those published earlier in the *JMAG* under "Report of the Mental Health Committee Meeting," April 1954.

Approved: The Report of the Committee on Mental Health.

5. COMMITTEE ON AWARDS—Hoke Wammock, Chairman. Wammock suggested that the Program Committee consider the practicability of a permanent type exhibit booth for use at MAG Annual Sessions. He also outlined the procedure for awards at the 1955 Annual Session. This is essentially the same as for those presented at the 1954 Annual Session.

Recommendation: On motion by Wammock, seconded by Poer, it was recommended that a letter of commendation be sent all scientific exhibitors participating in the 1954 Annual Session. The motion carried.

Approved: Report of the Committee on Awards.

6. COMMITTEE ON VETERANS AFFAIRS—Hartwell Joiner, Chairman. Joiner offered his support to Council and the Association in a letter to Council and outlined his committee's projects for the coming year. These projects are a continuation of the committee efforts in connection with veterans affairs.

Approved: The Report of the Committee on Veterans Affairs.

7. REPORT OF THE AMA DELEGATES—C. H. Richardson, Macon, and Eustace Allen, Atlanta. The three resolutions to be introduced by the Georgia delegates at the AMA San Francisco meeting were presented and discussed by Council. These resolutions were (1) Resolution on Veterans Affairs, (2) Resolution on Hospital Accreditation, and (3) Resolution on Small Hos-

pital Accreditation. Allen and Richardson asked Council to discuss and instruct them on the osteopathic problem which may come up at the San Francisco meeting.

Action Taken: On motion by Poer, seconded by Allen, it was recommended to withdraw the Resolution on Hospital Accreditation until such a time as it can be clarified. The motion carried.

A motion by Chambers, seconded by Allen, was made that Council go on record as disapproving the Cline Report, which would admit osteopathic graduates to medical schools and medical societies. The motion carried.

On motion by Poer, seconded by Hatcher, it was also recommended that a new resolution be introduced at the AMA meeting in San Francisco re the disapproval of the policy by the United States Navy of assigning medical officers to the examination of recruits in induction centers, and that this examination should be handled by private physicians on the local level. The writing of this motion was to be intrusted to the two AMA Delegates. The motion carried.

Approved: The Report of the AMA Delegates.

8. PUBLIC HEALTH COMMITTEE REPORT—T. F. Sellers. Sellers, acting in behalf of Chairman T. A. Sappington, asked for a discussion of the policies of admission at the new Eugene Talmadge Memorial Hospital in Augusta. A general discussion ensued.

Action Taken: On motion by Yeomans, seconded by Chambers, it was recommended that Rufus Payne, Superintendent of the Talmadge Memorial Hospital in Augusta, meet with the Executive Committee of Council and discuss this matter further, and that the Executive Committee after this meeting report back to the Council on this subject. The motion carried.

Approved: The Report of the Public Health Committee.

Committees from which no report was received are as follows: Honorary Advisory Board; Legislation; Scientific Work (to meet July 11); Professional Conduct; Rural Health; Woman's Auxiliary (to meet June 11); Hospitals; and State Medical Education Board.

9. MAG Building Improvement—David Henry Poer, Secretary-Treasurer. The Council was brought up-to-date on the reaction of the Fulton County Medical Society to the proposed MAG headquarters office building improvement. The Secretary-Treasurer was instructed to talk further

with the Board of Directors of the Fulton County Medical Society and report back to the Executive Committee of Council for action thereon.

10. MAG Journal—David Henry Poer, Secretary-Treasurer. On motion by Poer, Editor of the *JMAG*, seconded by Chambers, it was recommended to Council that Council appoint Edgar Woody, Jr., present Associate Editor of the *JMAG*, to the position of Editor of the *JMAG*. The motion carried.

11. Chairman Cheves called for, as the next order of business, any unfinished business. As there was none, Cheves called for new business. Under new business, Council members discussed the relationship between the MAG and the State Board of Medical Examiners. David Henry Poer pointed out that members of the State Board of Medical Examiners are not recommended by the MAG, but they are appointed by the Governor. He further stated that he felt they should be recommended by the MAG and forwarded to the Governor for appointment. He appointed out that this plan works successfully in other states.

C. H. Richardson made the suggestion that the Medical Practice Act be amended to admit only

physicians from Grade A schools and stated this should be done at the next meeting of the legislature. This suggestion was taken under advisement as it appears this policy is already adhered to in most cases by the State Board of Medical Examiners.

At the recommendation of Secretary-Treasurer David Henry Poer, certain changes in salaries for headquarters office personnel were approved by Council.

A professional conduct problem was discussed and it was advised that the headquarters office instruct the county medical society seeking clarification in this connection of the MAG Constitution and By-Laws which covers this specific matter.

A standing vote of thanks was given Chris J. McLoughlin, Atlanta, and Mark S. Dougherty, Jr., Atlanta, for their gracious hospitality in connection with the June 5-6 Council meeting.

A motion was made by H. L. Cheves, seconded by Poer, and approved, to hold the next Council meeting on September 19 at Lake Sinclair near Union Point with Councilman H. L. Cheves, host.

The meeting adjourned at 12:45 p.m.

Why Hurry?

The human body is a machine, with a mechanical ratio of units of fuel to energy output. The more effort one puts out, the more fuel is burned up. The faster an engine is driven, the greater amount of gasoline is consumed.

Frequently speed is necessary, calling for a little extra effort to complete a project, whether it means getting out one more letter, making one more telephone call, or meeting some emergency. If body and mind are coordinating well, the strain will not be too noticeable. But the person who day in and day out refuses to inject rhythm in his activities will show the strain.

Nervous tension can be avoided by learning to relax. Industry recognizes more and more that good output does not come from employees doing monotonous work. Today, such workers are given rest periods to break the monotony, if only for brief intervals.

Stabilizing the day's program will help reduce the need to hurry. Arising in the morning in sufficient time to dress and eat leisurely is the first step. Spacing and timing are important in setting up a working schedule, whether shopping for the family dinner or transcribing dictation of the day before. Calm thinking and rhythmic action will accomplish more than rushing about. Aside from the health aspect, the cosmetic and physical impression will be smoother. Hurry is not conducive to poise or to efficiency.

Stop crowding your activities. Too much of this while you are young will lessen your chances of growing old gracefully, not to mention the possibility of the many conditions that may result from tension: heart afflictions, high blood pressure, "nervous indigestion" and just plain bad disposition. Think it over and when you start to hurry—take it easy instead.

SOCIETIES

The FIRST DISTRICT MEDICAL SOCIETY met on May 26th in Statesboro, Georgia, with President Samuel F. Rosen presiding. Those presenting papers at the afternoon scientific session were Harold M. Smith, Savannah, "Treatment of Burns"; Ellison R. Cook III, Savannah, "Drug Therapy of Hypertension"; John Barksdale, Statesboro, "The Atherogenic Index—Its Practical Application"; and Thorburn S. McGowan, Savannah, "Recurring Pancreatitis and Its Treatment." Case Reports were presented by Albert M. Deal, David Robinson, Statesboro, and Miller Byne, Jr., Waynesboro. MAG President Peter B. Wright, Augusta, addressed the meeting as did Edgar Woody, Jr. and Mr. John Kiser, both of Atlanta. A cocktail party and banquet followed the scientific session. The Honorable Prince H. Preston, Statesboro, Member Congress, First Congressional District of Georgia, spoke on the subject "State Medicine, Yesterday and Today." John Mooney, Jr., Statesboro, was installed at this meeting as president of the First District society; John L. Elliott, Savannah, was elected president-elect; and

William F. Fulmer, Savannah, was re-elected secretary-treasurer.

The GEORGIA MEDICAL SOCIETY held its regular monthly meeting on June 8th in Savannah. Robert B. Greenblatt, Professor of Endocrinology at the Medical College of Georgia, Augusta, addressed the members on "Adrenal Tumors and their Symptomatology and Management." Mr. Milton Krueger, Executive Secretary of the Medical Association of Georgia, attended the meeting also.

The THOMAS COUNTY MEDICAL ASSOCIATION quarterly meeting was held at the Archbold Memorial Hospital, Thomasville, Ga., on June 16th. The meeting included a social hour, dinner and scientific meeting. Those presenting papers were Louis O. J. Manganiello, Augusta, "Enlarged Head in Infants"; Roy F. Stinson, Thomasville, "Wilm's Tumor"; and Fred E. Murphy, Thomasville, "Osteomyelitis In a Two Weeks Old Child," a case report.

The WARE COUNTY MEDICAL SOCIETY met recently at the Okefenokee Golf Club, Waycross, with A. W. DeLoach and Walter E. Lee, Jr. hosts. Neal F. Yeomans, Program Chairman, arranged a 30 minute tape recording of "Neuroses" by Walter C. Alvarez, well known specialist.

DEATHS

L. G. STEWART, Ellaville, 82, died at his home on June 2, 1954, after an illness of several months. A native of Schley County, Dr. Stewart was graduated from the Atlanta Medical College in 1895. He had practiced for many years in Ellaville before his retirement. Dr. and Mrs. Stewart, the former Mae Tondée, celebrated their 50th Wedding Anniversary last December. Dr. Stewart is survived by his wife, one daughter, Mrs. R. B. Strickland of Americus, five grandchildren, and two great grandchildren.

DOUGLAS RANDOLPH VENABLE, Columbus, 61, died May 27, 1954, of a heart attack. Dr. Ven-

able had been in ill health for several months. Dr. Venable was born in Sherman, Texas; he received his A.B. degree from Austin (Texas) College and his M.D. degree from the University of Texas in 1915. He did advanced study in Pathology at the Mayo Clinic, Rochester, Minn., and was a Fellow of the American College of Physicians. Coming to Columbus 14 years ago from Wichita Falls, Texas, he was first pathologist at City Hospital and later pathologist at St. Francis Hospital in Columbus. He was a member of the Masons and the First Presbyterian Church of which he was a former elder and deacon. He is survived by his wife, Mrs. Esther Lewis Venable, a son, James H. Venable, a student at Tulane Medical School, and a brother, Dr. Sidney C. Venable of Tulsa, Okla.

PERSONALS

C. C. AVEN, Atlanta, was recently given a unanimous vote of thanks by the health section of Metropolitan Atlanta Community Services for his eight year fight to secure local tuberculosis facilities. Of Dr. Aven it was said "there was never a more courageous, unselfish fight by anyone in the history of Atlanta than by Dr. Aven."

JOHN L. BARNER, Athens, spoke at the May Ladies Night dinner of the Cornelia Chamber of Commerce on the incidence of cancer, its discovery and new methods of treatment. The title of his address was "Weeds and Grass."

Dr. and Mrs. LEE BIVINGS, Atlanta, have returned from their round the world flight which included stops in Honolulu, Tokyo, Hong Kong, Manila, Singapore and Agra, India, where they visited the Taj Mahal. Also included in their itinerary were Istanbul, Brussels, Amsterdam and Paris.

LARRY BREGMAN, Atlanta, announces the removal of his offices to Suite 103, 950 West Peachtree Street, N.W., for the practice of pediatrics.

P. F. BROWN, Gainesville, has recently been made a member of the American Board of Surgery.

RANDALL G. BROWN, Swainsboro, moved in June to a suite of offices in the new, modern building at Church and Kite Road in Swainsboro.

JOHN CAMPBELL, Atlanta, was the leader of the second study session of the Carroll County Mental Hygiene Association. Dr. Campbell discussed "What Is Mental Illness?"

J. W. CHAMBERS, LaGrange, recently spoke to the LaGrange Rotary Club on the subject of rising medical costs.

R. E. DALLAS and W. J. GOWER, Thomaston, announce the association of R. J. MINCEY, who specializes in Obstetrics and Gynecology, to form the Dallas-Gower-Mincey Clinic, 211 E. Thompson Street in Thomaston.

E. B. DAVIS, Byromville, attended the fiftieth reunion of his class at the medical school of the University of Maryland. There he received his

second 50 Year Award in a month, the first being the MAG 50 Year Certificate.

MURDOCK EQUEN, Atlanta, attended the annual meeting of the American Laryngological Association which was held in Boston.

ERNEST FELBER, Atlanta, announces the removal of his offices to 950 West Peachtree Street, N.E. for the practice of Urology.

CHARLES FRIEDMAN and JOHN A. FAULKNER, Jr., Augusta, have formed a partnership for the practice of Orthopedic Surgery. The offices will be at 1142 Druid Park Avenue.

Dr. and Mrs. WADLEY GLENN, Atlanta, were hosts recently at a barbecue at their home in Dunwoody. This is an annual affair honoring the members of the Crawford W. Long Memorial Hospital staff and a group of interns who are leaving to begin practice.

ROBERT B. GREENBLATT, Professor of Endocrinology; G. LOMBARD KELLY, President-Emeritus of the Medical College of Georgia, and F. D. MULLINS, Acting Director of the Department of Pathology, all of Augusta, attended the meeting of the Houston County Medical Society in Dothan, Alabama in June. They discussed "Problems of Infertility."

LAURIER E. HACKETT, Camilla, has been admitted to the isolation ward of the Phoebe Putney Hospital in Albany with a case of what is reported to be a mild type of polio. We hope by this printing that Dr. Hackett has completely recovered.

W. D. HALL and R. D. WALTER, Calhoun, have presented to the Gordon County Hospital the Johnston-Hall Clinical medical library. Many of the 200 books originally belonged to the late Z. V. JOHNSTON.

WILLIAM G. HAMM and FRANK F. KANTHAK, Atlanta, are co-authors of a chapter on "Plastic Surgery" in the book published this year, *Seventy-Five Years of Medical Progress.*

JOHN MUNN HENG, a graduate in the class of 1954 from the Medical College of Georgia, was awarded a \$1,000.00 Mead Johnson General Practice Scholarship Award.

G. LOMBARD KELLY, Augusta, recently returned from a trip to Europe where he attended the marriage of his son, Mr. George Lockwood Kelly, to Miss Eva Reuter of Koblenz, Germany.

WILLIAM H. KISER, JR., Atlanta, stressed the fact that home and family are still the most important factors in rearing a child to be a successful adult, at a meeting of the Georgia Committee on Children and Youth, of which he is chairman. Dr. Kiser made a report on a recent conference on child and youth problems in Washington, D. C.

W. P. MARTIN, Summerville, who has been occupying the office of W. M. GIST while the latter was away in service, will move into new offices on West Washington Street in Summerville in July.

JOSEPH C. MASSEE, Atlanta, President of the Georgia Heart Association, has announced the opening of a Cardiac Clinic at St. Joseph's Infirmary in Atlanta. This brings to 13 the number of heart clinics established in Georgia under the sponsorship of the Georgia Heart Association. STERLING CLAIBORNE has been named first chief of the new clinic.

WILLIAM C. MCGARITY, Emory University, has been certified as a Diplomate of the American Board of Surgery.

MAX MICHAEL, Atlanta, has been named Professor of Medicine at the State University of New York College of Medicine and Director of Medical Services at Malmonide Hospital in Brooklyn. Dr. Michael is currently Associate Professor of Medicine at Emory University School of Medicine and Chief of Medical Services at the V. A. Hospital in Atlanta.

H. B. O'REAR and WEBSTER A. SHERRER, Augusta, have received grants from the Georgia Heart Association and the Damon Runyon Memorial Fund, respectively, to conduct research in the fields of heart disease and cancer.

W. W. OSBORNE, Springfield, announces the opening of his office for the practice of obstetrics. He will be in the office of TRACY OLMSTEAD each Wednesday morning.

J. R. PAULK and R. E. FOKES, Moultrie, announce the formation of the Eye, Ear, Nose and Throat Clinic in Moultrie, in association with JAMES T. FLYNN, JR., Atlanta.

JOHN H. REED, Gainesville, announces the opening of his office for the practice of Ophthalmology, at 228 North Green Street.

CHARLES H. RICHARDSON, SR., Macon, served on the Hygiene, Public Health and Industrial Health Reference Committee at the recent AMA

House of Delegates meeting in San Francisco.

ALBERT A. ROSENBERG, Atlanta, announces the removal of his offices to 950 West Peachtree Street, N.W.

ILONA D. SCOTT, Milledgeville, has been named Chief of the Department of Radiology at the Veterans' Administration Hospital in Tuscaloosa, Alabama.

JACK D. STANDIFER, Blakely, Mayor of Blakely, received the Georgia Local Government Journal Honor Roll award for the month of May.

The massive granite amphitheatre built in Lithonia's park near the school and recreational facilities has been named in honor of THOMAS W. STEWART. The dedication ceremonies were held on "Community Progress Day," June 23, 1954, with Governor Talmadge and other state and county officials present.

HOMER SWANSON, Atlanta, announces the removal of his office to Suite 303 Medical Arts Building, 384 Peachtree Street, N.E. for the practice of Neurological Surgery.

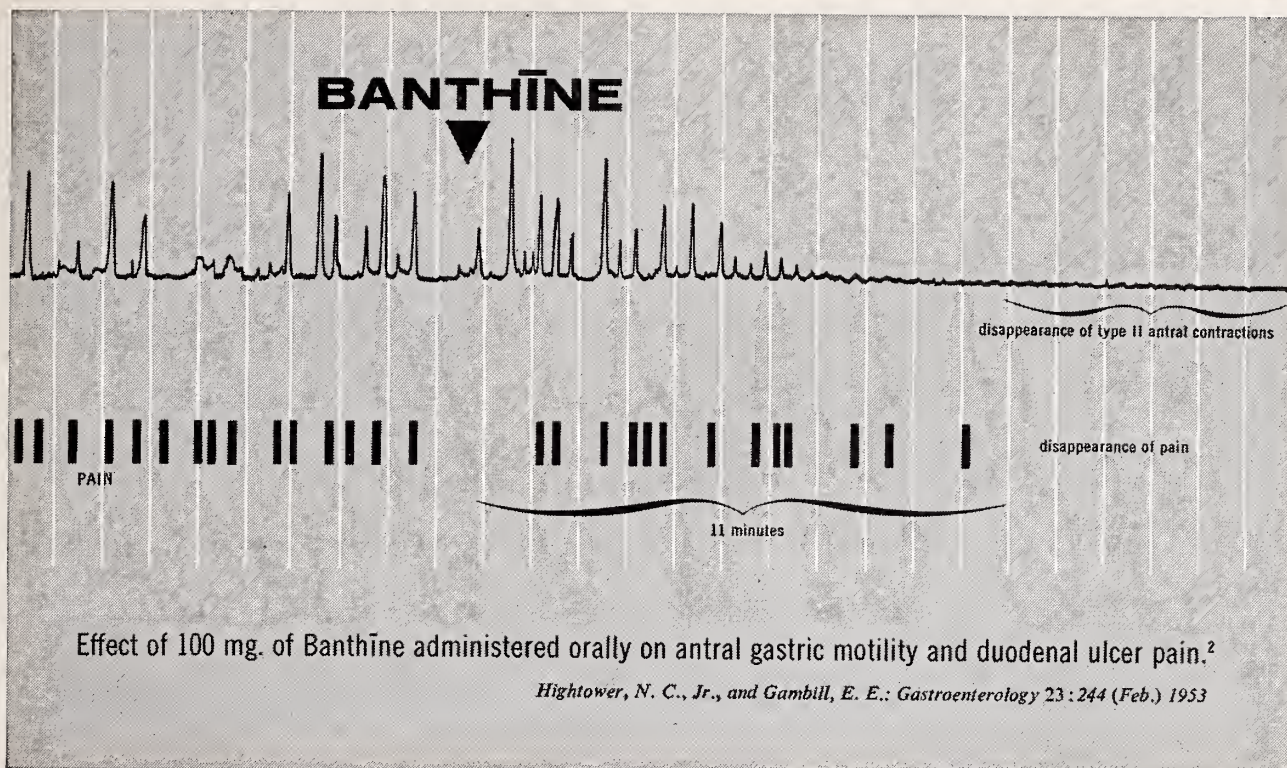
ALBERT S. TRULOCK, JR., Albany, has resigned his position as Chief of the Surgical Service at the V.A. Hospital, Montgomery, Alabama, to enter private practice in Albany. His offices, for the practice of general surgery, will be located at 121 Oglethorpe Avenue.

HOKE WAMMOCK, Augusta, has been made a member of the American Cancer Research Association and has also been given full membership in the Georgia Chapter of Sigma Xi.

Dr. and Mrs. J. B. WARNELL, Cairo, observed their Golden Wedding Anniversary in June with an informal "open house."

A. CALHOUN WITHAM, Augusta, attended the meeting of Cardiovascular Program Directors or Representatives in Ithaca, N. Y. This meeting was a conference on teaching. Following the meeting he was invited to observe methods employed at the Peter Bent Brigham Hospital in Boston, Mass.

Plans have been announced by O. C. WOODS, CHARLES FULGHUM, HOWARD CARY and E. Y. WALKER, Milledgeville, to build a new doctors' building in Milledgeville to house the Richard Binion Clinic. There will be space for a number of other doctors to have offices there, also.



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Ruffin, J. M.; Texer, E. C., Jr.; Carter, D. D., and Baylin, G. J.: J.A.M.A. 153:1159 (Nov. 28) 1953.

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3:00 to 3:30—Cancer of the Female Generative Organs—Dr. Conrad G. Collins, New Orleans, La.

3:30 to 4:00—Cancer of the Lung—Dr. M. Bedford Davis, Atlanta, Ga.

4:00 to 4:30—Report of the International Cancer Conference at Sao Paulo, Brazil—Dr. Robert L. Brown, Atlanta, Ga.

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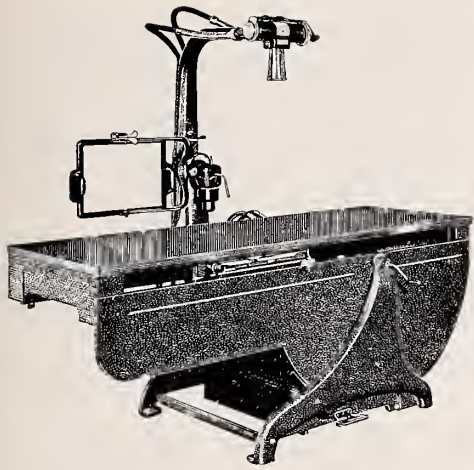
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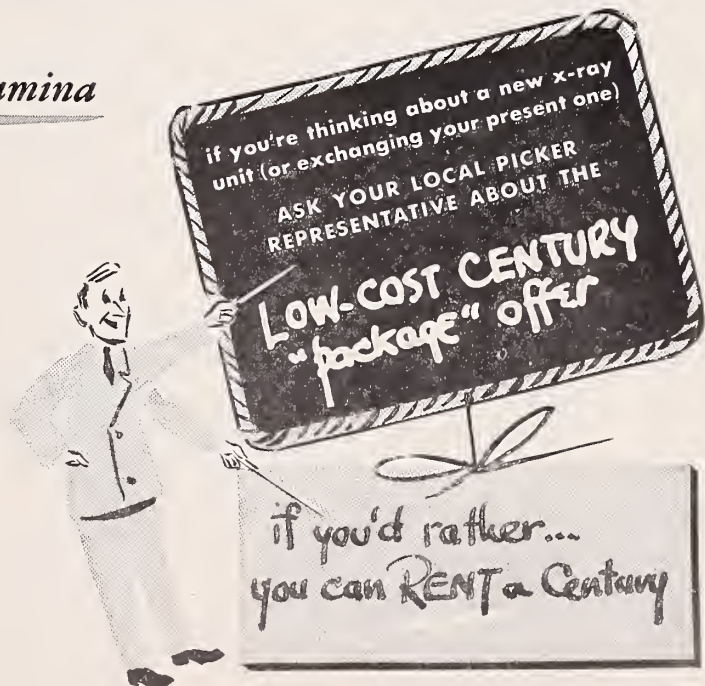


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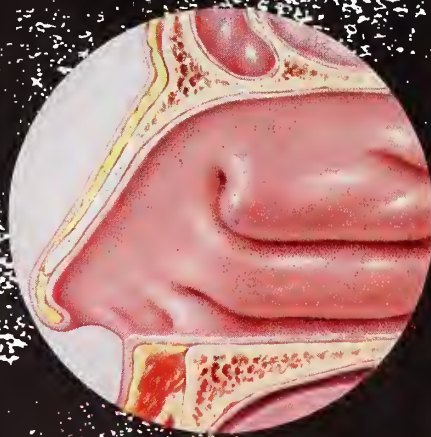
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No other medication given.



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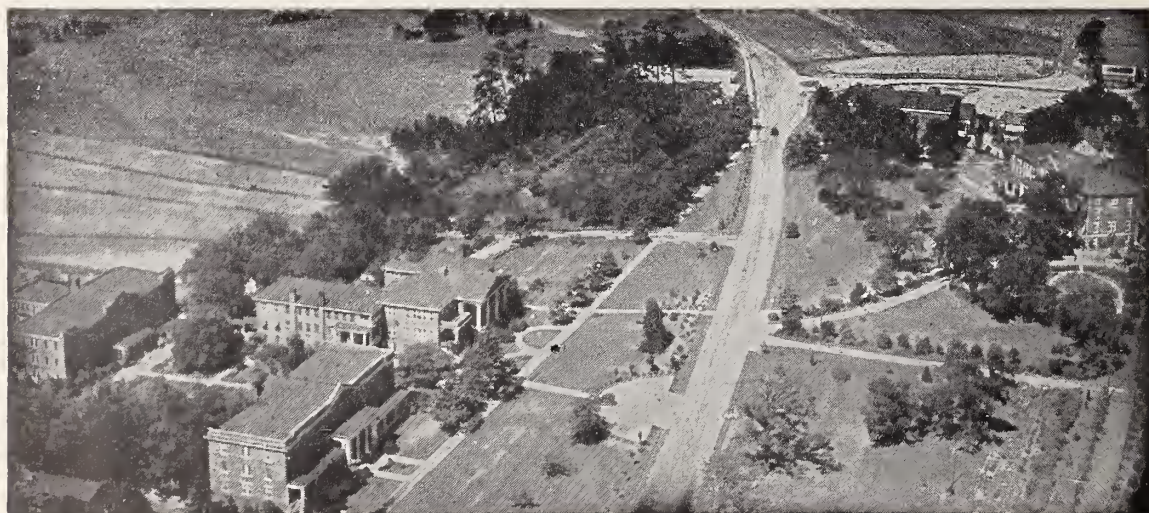
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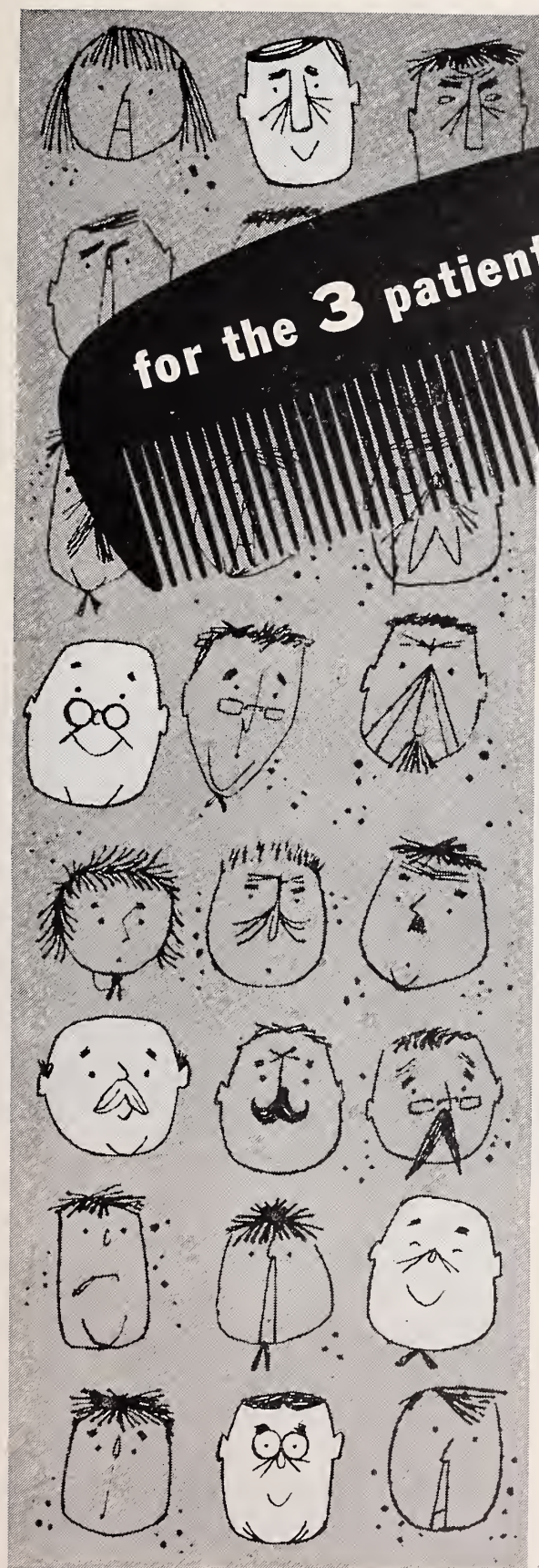
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1. Slepyan, A. H. (1952), Arch. Dermat. & Syph., 65:228, February. 2. Slinger, W. N. and Hubbard, D. M. (1951), *ibid.*, 64:41, July. 3. Sauer, G. C. (1952), J. Missouri M. A., 49:911, November.

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*Heck, W.E.; Lynch, W.J., and Graves, H.L.: *Acta oto-laryng.* 43:416, 1953.

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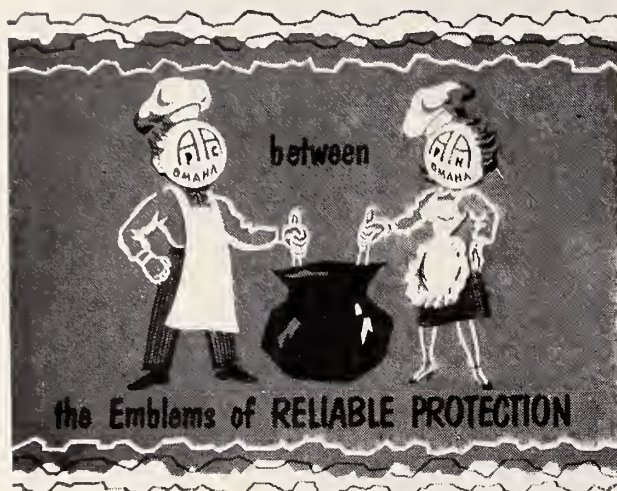
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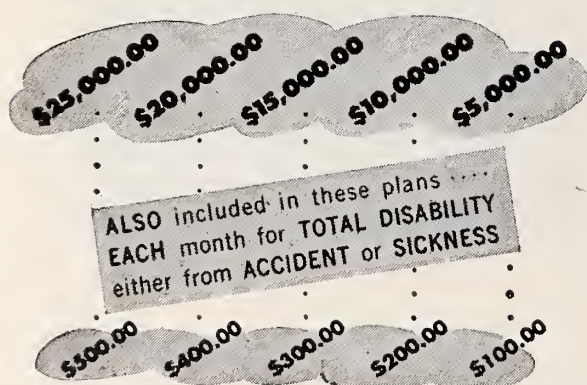
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This new filter is made of a filtering material so efficient it has been used to purify the air in atomic energy plants of microscopic impurities.

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it removes nicotine and tar particles as small as $2/10$ of a micron.

And yet KENT's Micronite Filter, which removes a greater percentage of nicotine and tar than any other filter cigarette, lets through the full flavor of KENT's fine tobaccos.

Because so much evidence indicates KENT is the most effective filter-tip cigarette, shouldn't it be the choice of those who want the minimum of nicotine and tar in their cigarette smoke?

Kent

with the exclusive Micronite Filter

"KENT" AND "MICRONITE" ARE REGISTERED TRADEMARKS OF P. LORILLARD COMPANY



HIGHLAND HOSPITAL, INC.

Founded in 1904

ASHEVILLE

NORTH CAROLINA

Affiliated with Duke University



A non-profit psychiatric institution, offering modern diagnostic and treatment procedures—insulin, electroshock, psychotherapy, occupational and recreational therapy—for nervous and mental disorders.

The Hospital is located in a 75-acre park, amid the scenic beauties of the Smoky Mountain Range of Western North Carolina, affording exceptional opportunity for physical and nervous rehabilitation.

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FOR NERVOUS AND MENTAL DISEASES AND ADDICTIONS

Insulin and Electro-Shock Therapy Used in Selected Cases. Gradual Reduction Method Used in the Treatment of the Addictions

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Phones 9-1151 and 9-1152

here's why your patient gets



3:15—Disintegration Test begins in actual stomach fluids (pH 2.7). Beaker at left contains ordinary enteric-coated erythromycin. At right is new FILMTAB* ERYTHROCIN Stearate (Erythromycin Stearate, Abbott).

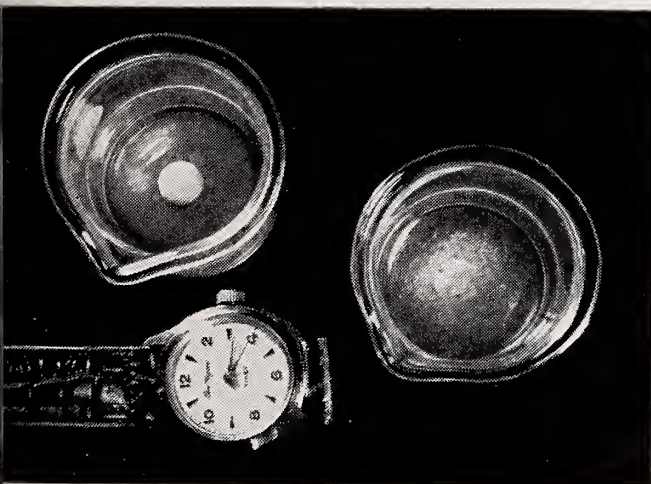
Earlier Blood Levels *from*



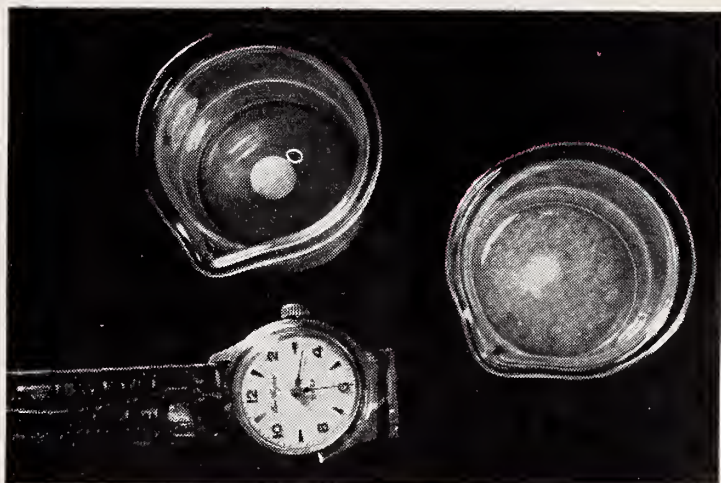
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DISINTEGRATES FASTER THAN ENTERIC COATING

HIGH BLOOD CONCENTRATIONS WITHIN 2 HOURS



—Five minutes later, *Filmtab** coating has already begun to disintegrate. The tissue-thin film actually begins to dissolve within 30 seconds after patient swallows tablet.



3:30—*Filmtab** is now completely dissolved. At this stage, ERYTHROCIN is ready to be absorbed, and ready to destroy sensitive cocci—even those resistant to other antibiotics.



—Now the *Filmtab** tablet mushrooms out with all of the drug available for absorption. Note that enteric-coated tablet is still intact. Tests show that the new Stearate form completely protects ERYTHROCIN against gastric acids.



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The JOURNAL of the MEDICAL ASSOCIATION OF GEORGIA

875 West Peachtree, N. E.
Atlanta, Georgia

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Ordinarily articles should not exceed 3,000 words. Only under exceptional circumstances will articles of over 4,000 words be published. Footnotes, bibliographies and legends should be typed on separate sheets, double-spaced. Bibliographies should conform to the style of the Quarterly Cumulative Index published by the American Medical Association—i.e., name of author, title of article, name of periodicals with volume, page, month, day of month if weekly and the year. They should be listed in alphabetical order and numbered in sequence. Example: 1. Jones, S. R.: Spontaneous Epistaxis, Arch. Int. Med., 36:434 (Dec.) 1946.

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people need a doctor?"

We're telling the millions of readers of LIFE, TIME,

Saturday Evening POST, NEWSWEEK, and TODAY'S HEALTH

-All of them!"

message shown on the opposite page is the advertisement in Parke, Davis & Company's "See Your Doctor" campaign which has been continuously published for the past 26 years.

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Seven of these messages are reprinted in the booklet, "Your Doctor and You." If you wish a few copies for your reception room table, please let us know.



PARKE, DAVIS & COMPANY

Research and Manufacturing Laboratories, Detroit, Michigan



"These tablets
keep the swelling down
all day long."

TABLET

NEOHYDRIN[®]

BRAND OF CHLORMERODRIN

NORMAL OUTPUT OF SODIUM AND WATER

Individualized daily dosage of **NEOHYDRIN** -- 1 to 6 tablets a day as needed -- prevents the recurrent daily sodium and water reaccumulation which may occur with single-dose diuretics. Arbitrary limitation of dosage or rest periods to forestall refractivity are unnecessary. Therapy with **NEOHYDRIN** need never be interrupted or delayed for therapeutic reasons. Because it curbs sodium retention by inhibiting succinic dehydrogenase in the kidney only, **NEOHYDRIN** does not cause side actions due to widespread enzyme inhibition in other organs.



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COVER — Photography Editor Ted F. Leigh presents a composite view of "Four Years of Medical School."

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The JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA, established 1911. Owned, edited and Copyright, 1954 by the Medical Association of Georgia, 875 West Peachtree Street, N.E., Atlanta, Georgia. Published monthly under the direction of the Council of the Association. Subscription rates: \$5 per year; \$1 per single copy. Entered as second-class mail at the post office at Atlanta, Georgia, under the Act of March 3, 1879. Accepted for mailing for the general rate of postage provided for in Section 1103, Act of October 6, 1917, authorized November 14, 1928.

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. . . reduces nasal engorgement . . .

promotes aeration . . . encourages drainage

0.25% Solution (plain and aromatic)

0.5% Solution; 0.25% Spray (unbreakable plastic squeeze bottle)

1% Solution

0.5% water soluble Jelly

I. Van Alyea, O. E., and Donnelly, Allen: *Arch. Otolaryng.*, 49:234, Feb., 1949.

A few drops of Neo-Synephrine 0.25% in each nostril will promptly check mucosal engorgement and hypersecretion, promoting greater breathing comfort over a period of several hours.

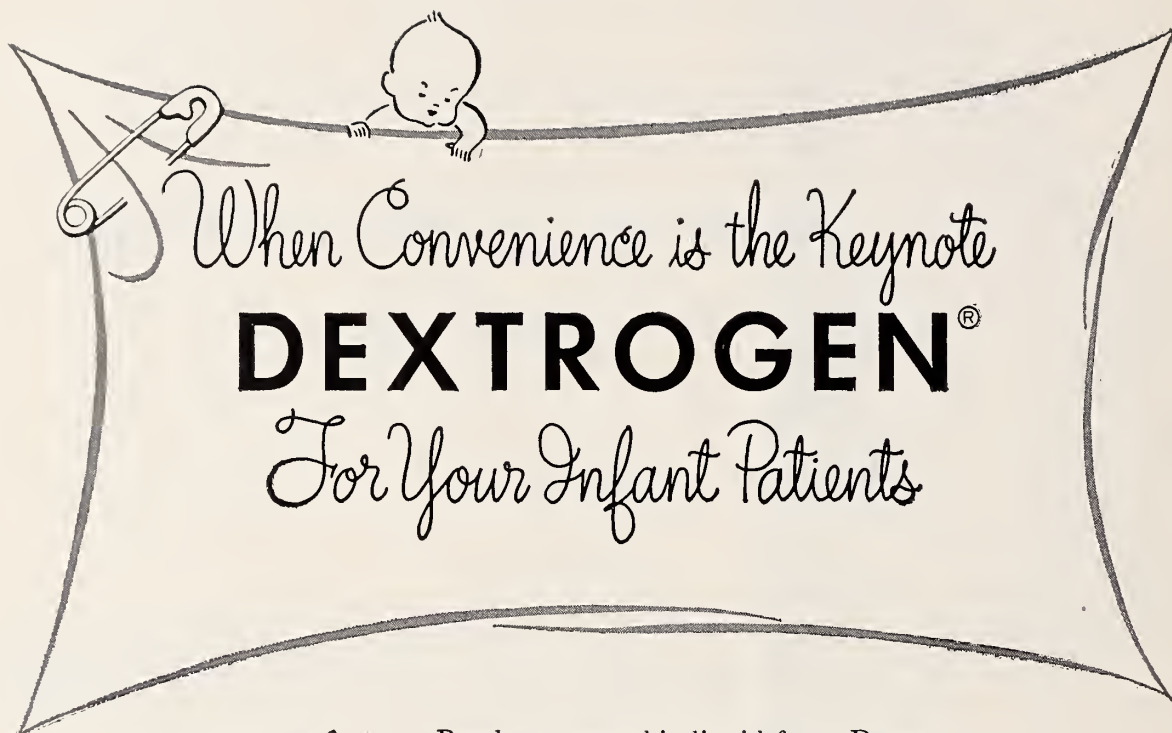
The resultant relief to the hay fever sufferer is decidedly gratifying. Prolonged action of Neo-Synephrine makes fewer applications necessary, consequently longer periods of rest and sleep are possible.

Neo-Synephrine does not lose its effectiveness on repeated application and may, therefore, be relied upon to give relief throughout the hay fever season.

Neo-Synephrine is practically free from sting and compensatory congestion; does not appreciably inhibit ciliary activity. Neo-Synephrine has been found relatively free from systemic side effects such as nervous excitation, cardiac reaction or insomnia even when tested on hypertensive, cardiac and hyperthyroid patients.¹

Winthrop-Stearns INC.
NEW YORK 18, N. Y. WINDSOR, ONT.

Neo-Synephrine, trademark reg. U.S. Pat. Off., brand of phenylephrine.



Ready to use and in liquid form, Dextrogen is a concentrated infant formula, made from whole milk modified with dextrans, maltose, and dextrose. In addition, it is fortified with iron to compensate for the deficiency of this mineral in milk. Diluted with $1\frac{1}{2}$ parts of boiled

water,* it yields a mixture containing proteins, fats and carbohydrates in proportions eminently suited to infant feeding. In this dilution it supplies 20 calories per ounce.



The higher protein content of normally diluted Dextrogen—2.2% instead of 1.5% as found in mother's milk—satisfies every known protein need of the rapidly growing infant. Its lower fat content makes for better tolerability and improved digestibility.

Dextrogen serves well whenever artificial feeding is indicated, and is particularly valuable when convenience in formula preparation is desirable.

*Applicable third week and thereafter; 1:3 for first week, 1:2 for second week.

THE NESTLÉ COMPANY, INC.

Professional Products Division
WHITE PLAINS, NEW YORK



**NOTE HOW SIMPLE
TO PREPARE**

All the mother need do is pour the contents of the Dextrogen can into a properly cleaned quart milk bottle, and fill with previously boiled water. Makes 32 oz. of formula, ready to feed.*



president's page

There has been much concern throughout the Medical Profession of Georgia over the possible policies for the operation of the Eugene Talmadge Memorial Hospital.

On Sunday, July 11th, the Executive Committee of the Council of the Medical Association of Georgia met in Augusta and had Chancellor Harmon Caldwell, Dr. Lee Rogers, President of the State Board of Health, Dr. T. F. Sellers, the Honorable Roy V. Harris of the Board of Regents, Dr. Thomas W. Goodwin, member of the State Board of Health and Dr. Joe Mulherin, Secretary of the Richmond County Medical Society present in order to listen to Dr. Rufus Payne present the proposals and for a general discussion.

Out of this meeting there was developed a committee to be composed of three members appointed from the Board of Regents, three from the State Health Department and three from the Medical Association of Georgia. It was agreed by all present that the operation and policies of this hospital which is to be run in conjunction with the Medical College of Georgia must be completely legal and not violate the Code of Ethics of the American Medical Association.

This committee will endeavor to formulate policies for the operation of said hospital and before their adoption they shall be submitted to the American Medical Association for their approval as well as to the various County Medical Societies in the State of Georgia.

It is my firm belief that such policies can be designed and if carried out will cause no friction amongst the Medical Profession of Georgia.



Brain Wave Laboratory

THE SISTERS OF MERCY of St. Joseph's Infirmary recently announced the opening of the new Brain Wave Laboratory at that institution. The addition of this completely equipped department for clinical electroencephalography is one of a series of developments in special diagnostic facilities which have taken place since the opening of the new hospital last December. The technique is being used increasingly not only by those in the neurological fields but by internists, pediatricians and others in diagnosis and prognosis in disorders affecting the central nervous system. Since the technique is painless, without risk and does not require hospitalization in most instances, much of the laboratory's work is done on outpatients.

The laboratory is housed in the Courtland Street Building and contains 750 square feet of floor space subdivided into preparation room, of-

fice, instrument room and shielded patient room. Air-conditioning has been utilized to improve the quality of the recordings. Basic technical instruments are the Grass III-D eight channel electroencephalograph and the Grass PS-I photic stimulator.

Technician-in-charge is Mr. Albert Drolet, formerly of the Queen Mary Veterans and the Notre Dame Hospitals of Montreal, Canada. The laboratory is under the supervision of an active member of the surgical staff (Neurosurgery) of St. Joseph's Infirmary. The facilities of the laboratory are available to all practicing physicians. Appointments for outpatients may be scheduled with the technician-in-charge. Patients from State Agencies (Division of Vocational Rehabilitation and the Crippled Children's Division) will be accepted on the basis of arrangements already concluded with these agencies.

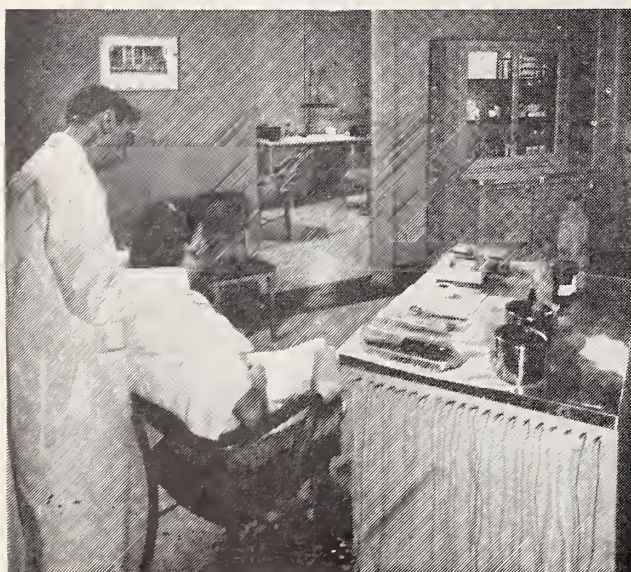


Figure 1—Scalp electrodes are applied in central preparation room. Office and record storage room are in background.

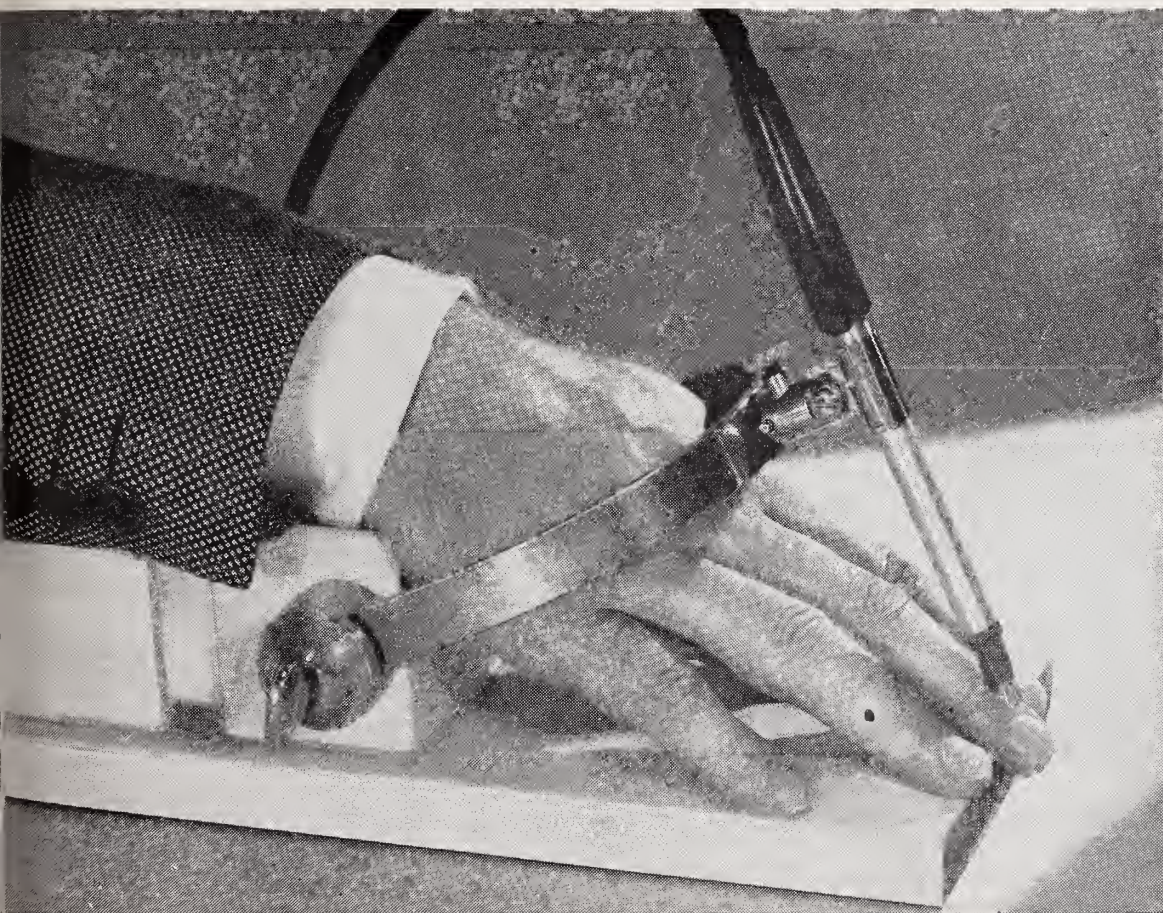


Figure 2—During recording the patient reclines in a shielded room to the left under observation by the technician.

Physiological test

compares Kent's

"Micronite" Filter with other cigarette filters



"KENT" AND "MICRONITE"
ARE REGISTERED TRADEMARKS
OF P. LORILLARD COMPANY

o compare the efficiency of various filters as they affect physiological responses in the cigarette smoker, drop in surface skin temperature at the last phalanx was measured.

Using well-established procedures, the subject smoked conventional filter cigarettes and the new KENT with the exclusive Micronite Filter.

For every other filter cigarette, the drop in temperature averaged over 6 degrees. For KENT's Micronite Filter, there was no appreciable drop.

These findings confirm the results of other scientific measurements that show these facts: 1) KENT's Micronite Filter takes out *far more* nicotine and

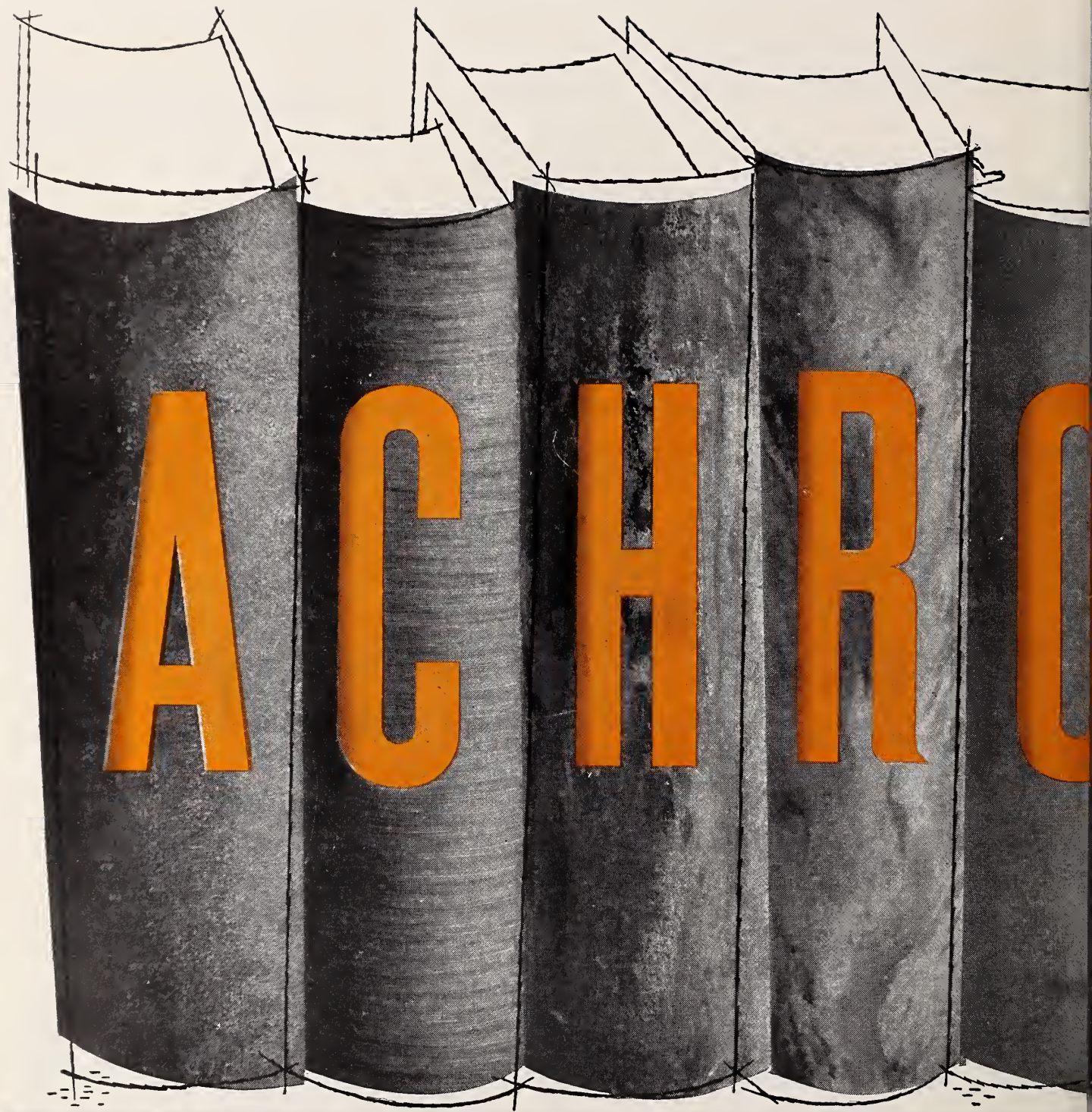
tars than any other cigarette, *old or new*. 2) Ordinary cotton, cellulose or crepe paper filters remove a small but ineffective amount of nicotine and tars.

Thus KENT, with the first filter that really works, gives the one smoker out of every three who is susceptible to nicotine and tars the protection he needs . . . while offering the satisfaction he expects of fine tobacco.

For these reasons, smokers have made the new KENT the most popular new brand of cigarette to be introduced in the last 20 years.

If you have yet to try the new KENT with the exclusive Micronite Filter, may we suggest you do so soon?





Medical history is being written today



• REG. U.S. PAT. OFF. •



Hydrochloride
Tetracycline HCl *Lederle*

The introduction and rapid widespread adoption of ACHROMYCIN has opened a new chapter in the history of broad-spectrum antibiotics.

ACHROMYCIN fulfills the requirements of the ideal antibiotic in virtually every respect . . . wide-range antimicrobial activity, *in vivo* stability, tissue penetration, minimal toxicity.


ACHROMYCIN is truly a broad-spectrum weapon, effective against Gram-positive and Gram-negative

bacteria, as well as certain mixed infections.

ACHROMYCIN is more stable and produces fewer side effects than certain other broad-spectrum antibiotics.

ACHROMYCIN provides prompt diffusion in body tissues and fluids.

ACHROMYCIN is destined to play a major role among the great therapeutic agents.



Karo Syrup... a carbohydrate of choice

in milk modification for 3 generations

OPTIMUM caloric balance — 60% of caloric intake, gradually achieved in easily assimilable carbohydrates—is assured with Karo. Milk alone provides 28%, or less than half the required carbohydrate intake.

A MISCIBLE liquid, Karo is quickly dissolved, easy to use, readily available and inexpensive.

A BALANCED mixture of dextrins, maltose and dextrose, Karo is well tolerated, easily digested, gradually absorbed at spaced intervals and completely utilized.

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Cardiac Catheterization

CARDIAC CATHETERIZATION in the diagnosis of structural disease of the heart is a procedure now well established. It is best employed in cases of congenital heart disease, where the information afforded is always helpful, often surprising, and very often conclusive.

Less than two decades ago there was little interest in congenital heart disease; it was a lesion comparatively rare, difficult or impossible to diagnose, and hopeless of correction. Advances in thoracic surgery and careful cardiac catheterization have changed this picture. There are today at least five types of congenital heart disease in which the surgical results are excellent, and several types where the results may be excellent when proper techniques are perfected. With good surgery available, it becomes necessary for the internist and the pediatrician to diagnose accurately the congenital heart lesion. In most instances one can know what the lesion is without opening the chest, and in this respect cardiac catheterization shares at least equal honors with angiocardio-graphy.

Cardiac catheterization is technically more simple and less dramatic than the name would suggest, involving merely a cut-down incision into an arm vein and the insertion of a blunt-tipped ureteral-type catheter into the right heart and pulmonary artery under fluoroscopic control.

To appreciate what information catheterization gives, it is well to recall that in the normal human heart the right and left chambers and the greater and lesser circulations are anatomically and functionally separate. The oxygen concentration of blood in each side of the heart remains relatively constant for that side, and one would thus expect

to find the same oxygen content in the superior vena cava as in the pulmonary artery or its branches. While it is well known that there is a marked difference in pressure between right and left-sided cardiovascular structures, it is not generally appreciated that the pressure in the right heart is as low as it is (15-20 mm Hg. systolic). Normally, equal amounts of blood traverse the pulmonary artery and aorta, and the one-way valves between chambers and vessels are thin and pliable, separating easily and approximating closely.

In congenital heart disease this orderliness of the normal circulation is upset. An abnormal communication between two adjacent vascular structures (auricles, ventricles, arteries) permits shunting and admixture of blood; a narrowed or atretic valve orifice changes entirely the pressure relationship between two contiguous structures (as between right ventricle and pulmonary artery in pulmonic stenosis); and the abnormal development or origin of a great vessel may allow that vessel to receive blood it does not normally carry (as in over-riding aorta). These defects may exist separately or they may co-exist, as in Tetralogy of Fallot.

Given such a situation, there are two basic types of information obtainable by catheterization which may suffice for diagnosis: (1) the blood pressure in the various stations of the right heart and pulmonary artery, and (2) the oxygen saturation of the blood at these points. A third type of information, the mechanical demonstration of an abnormal communication by catheter tip placement and direct visualization, is too infrequently accomplished to be relied upon.

Notes on practical aspects of cardiovascular diseases . . .
a monthly contribution of the Georgia Heart Association.

The indwelling catheter when connected to a recording device will show a pressure curve distinctive for each chamber, and, as it happens, distinctive for certain lesions (tricuspid insufficiency, constrictive pericarditis). More often it is the pressure difference between chambers rather than the character of the curve that is of diagnostic importance, as in pulmonary stenosis, where the catheter records a normal or diminished pressure in the pulmonary artery and a strikingly high pressure in the right ventricle.

The blood samples taken through the indwelling

catheter often show differences in oxygen saturation that are diagnostic. At a certain point in the sampling process one may note a sudden increase in the oxygen content of the blood, indicating contamination with arterial blood from the left side of the heart. Auricular and ventricular septal defect and patent ductus arteriosus are diagnosed in this manner.

Cardiac catheterization is indicated in all but the most obvious types of congenital heart disease, and it is now established as a procedure which offers little discomfort or danger to the patient and yields valuable diagnostic information.

Georgians Win Hektoen Silver Medal

Theodore J. Bauer, Medical Officer in Charge, Communicable Disease Center, Atlanta, Georgia, announced that Gerald R. Cooper and Emanuel E. Mandel were awarded the Hektoen Silver Medal for their exhibit of an original investigation at the American Medical Association meeting in San Francisco on June 21-25. The investigation was conducted in the Communicable Disease Center laboratory located at Grady Memorial Hospital and was accomplished as a joint project between the Communicable Disease Center, the Emory University School of Medicine and the medical staff of Grady Memorial Hospital. Their exhibit, entitled "Paper Electrophoresis in Clinical Diagnosis," described their equipment and procedure, the clinical results of their studies of various diseases and the advantages and limitations of their method in making diagnoses.

The apparatus and techniques were developed as part of a research program to determine the different ways that a person reacts to infectious agents such as bacteria, viruses, parasites and fungi. Since the blood serum proteins bathe every cell in the body, it was felt that they should reflect any protein abnormalities that might develop in various diseases and that their changes might help to diagnose the disease. Because proteins

each have a different electric charge, they can be separated by placing them in an electric field and allowing them to move to the poles. Paper electrophoresis is a means of applying the current to one drop of blood serum on a strip of wet paper until the individual proteins have moved apart. This method of separation may also be applied to the other body fluid components which carry a charge, such as hemoglobin and lipids, in some instances supplying information which is not available from any other procedure.

The simple and inexpensive electrophoresis cells which were designed and built are suitable for use in hospitals or in private laboratories. The instrument separates five important blood proteins that vary in amount and composition in different diseases. The paper containing these proteins is stained to make a pattern which can be analyzed to show how much of each protein is present. Variations are detected by a photoelectric cell in a densitometer and recorded automatically by an electrocardiograph. The graphs obtained with this instrument can be compared with graphs from other patients and from people in normal health to diagnose diseases or to follow the course of an illness.

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1. Parsons, L., and Tenney, B., Jr.:
M. Clin. North America 34:1537,
1950.

2. Greenblatt, R. B.: J. Clin. En-
docrinol. & Metab. 13:828, 1953.

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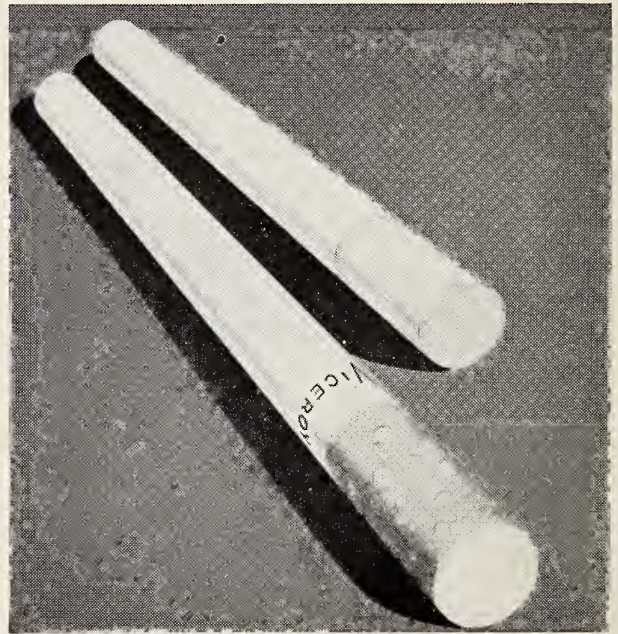


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the executive secretary's letter

National Boards

The State Board of Medical Examiners recently voted to "accept those otherwise qualified applicants who successfully completed the National Board of Medical Examiners requirements and examination prior to October 15, 1953." The State Board is not accepting applicants who completed the National Boards after that date.

Good Advice

Check your malpractice insurance and be certain that you are adequately covered by your insurance. This is the advice given by Reference Committee No. 4 after reviewing the Medical Defense Committee Report at the Annual Session in Macon. The Reference Committee report stated, "Twenty-seven malpractice suits were reported during the past year, which is a considerable increase over those occurring in previous years. The committee takes the liberty of recommending to the members of the Medical Association of Georgia that they check their malpractice insurance and be certain that they are adequately covered by this insurance. The committee further recommends that each member of the Medical Association of Georgia check his insurance coverage since any bodily injury incurred in the doctor's office is not covered by malpractice insurance, and we feel that this should be called to their attention.

"The Reference Committee feels that, after due consideration, it is our duty to call to the attention of the members of the Medical Association of Georgia their responsibility in not settling unjust claims in order to expedite the closing of a case; we feel that this would simply encourage unscrupulous parties to enter suit more frequently and to cause added expense and embarrassment."

Emphasis on Ethics

Your attention is called to an editorial on medical ethics in this issue. This is the second editorial on ethics that has been published in the *Journal* in recent months. The MAG Council has been very much concerned with the problem of acquainting members with the Code of Ethics. Medical ethics has been a subject that has been in the headlines of the national press, and it is a problem about which every member of the Asso-

ciation should be concerned. It concerns not only the delinquent minority, but also the righteous majority who complain about the "bad publicity" but do nothing to prevent it.

Plans for 1955—See Back Cover

Much work has already been accomplished by the headquarters office toward the 1955 Annual Session to be held at the Bon Air Hotel, Augusta, May 1-4. A meeting of the Scientific Work Committee together with the Section Program Chairmen was held at Bon Air Hotel July 11. At this meeting the general outline of the Augusta program was established, and section program chairmen were asked to furnish the headquarters office with complete details of their programs by October 1. One entire day's program during the 1955 session will be turned over to the general practitioners. On that day, Tuesday, May 3, speakers will present papers of interest to GP's. This GP day program will be similar to the general session programs that have been a routine part of the MAG Annual sessions for many years.

Hektoen Silver Medal

The Hektoen Silver Medal Award for the second best scientific exhibit at the recent AMA San Francisco meeting was presented to two Atlanta men, Gerald R. Cooper and Emanuel E. Mandel who are associated with the Communicable Disease Center and Emory University School of Medicine. Their prize-winning exhibit was entitled "Paper Electrophoresis in Clinical Diagnosis."

Dates to Remember

Don't forget the Emory Medical School Centennial Celebration to be held October 4 and 5. Five internationally-known medical leaders will speak on Monday the 4th, and the formal academic ceremony will take place on Tuesday. . . . The Georgia Medical Society's Sesquicentennial Celebration will be held October 11 and 12 in Savannah. The Georgia Medical Society of Savannah is the second oldest medical society in the country. . . . The Georgia Academy of General Practice will hold its Sixth Annual Session October 20 and 21 at the Biltmore Hotel, Atlanta.

John F. Kiser

Asst. Executive Secretary

the month in washington

Amendment to Hill-Burton Act

Washington, D. C.—During the next three years the federal government expects to help finance the construction of thousands of new medical and dental facilities—diagnostic-treatment clinics, vocational rehabilitation centers, nursing homes, and chronic disease hospitals. Only three strings are attached: the facilities must be non-profit, they must be under medical or dental supervision, and local communities must raise part of the cost.

Legislation establishing the new program was enacted just as Congress plunged into its adjournment rush, and before it had come to final decisions on reinsurance and other major controversial bills in the health field.

The new operation was authorized by amending the Hill-Burton Act (passed in 1946 to assist hospitals) to permit grants to units that do not qualify as hospitals. Under the original Hill-Burton law, grants could be made to rehabilitation centers and diagnostic-treatment clinics only if they were attached to hospitals. Grants could also be made to chronic disease hospitals. The new law authorizes help to centers and clinics operating on their own, a provision Public Health Service expects to be of particular assistance to smaller communities. It also offers aid to nursing homes, which previously were not covered.

In the case of chronic disease hospitals, it is explained that the law offers two new inducements for construction: 1. Money is allocated to the state and earmarked for this particular type of hospital. 2. The federal government will be able to pay 50 per cent or more in all cases, whereas under the old law the U. S. share was as low as one-third in some of the higher-income states.

Grants to clinics, centers, and nursing homes will have to wait on state surveys to determine priorities, according to U. S. hospital officials. However, if local sponsors take the initiative, grants can be processed immediately for chronic disease hospitals, as earlier Hill-Burton surveys have established their priorities. Failure of communities to construct chronic disease hospitals was one of the disappointments of the first Hill-Burton program.

The first year's appropriation will be \$37.4 million, increasing over the next three years until the total authorization of \$182 million has been reached. The new projects in no way interfere with the regular Hill-Burton grants for construction of hospitals, for which \$75 million is available this year.

Reinsurance Bill

The final flurry over the reinsurance bill was preceded by a concerted drive by the administration. The President himself interceded with insurance company officials, and Secretary Hobby agreed to amendments in an effort to satisfy the state insurance commissioners. The commissioners, who would have an important role in administering the reinsurance program, at first had flatly opposed it. President Walter B. Martin and other A.M.A. officials were called in for a discussion of reinsurance at the Department of Health, Education, and Welfare, and later Sherman Adams, assistant to the President, also invited Dr. Martin to a White House meeting on the same subject.

Medical Care for Military Dependents

As expected, bills for a new program of medical care of military dependents were left stranded when adjournment time approached. Before he introduced his bill on the subject, Chairman Dewey Short of the House Armed Services Committee insisted that Defense Department estimate first year's additional cost of the program. The estimate was \$67 million.

Appropriations

For the current fiscal year, the Department of Health, Education, and Welfare has available \$1,663,413,761. The appropriation bill is \$10,904,500 more than the administration requested but under last year's budget of \$1,927,432,261 (the decline explained by decreased public assistance grants to states). Public Health Service has \$228,060,000 for its regular programs.

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A comprehensive review of the physics and higher mathematics involved, film interpretation, all standard general roentgen diagnostic procedures, methods of application and doses of radiation therapy, both x-ray and radium, standard and special fluoroscopic procedures. A review of dermatological lesions and tumors susceptible to roentgen therapy is given, together with methods and dosage calculation of treatments. Special attention is given to the newer diagnostic methods associated with the employment of contrast media, such as bronchography with Lipiodol, uterosalpingography, visualization of cardiac chambers, perirenal insufflation and myelography. Discussions covering roentgen departmental management are also included; attendance at departmental and general conferences.

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A systemic series of lectures is presented covering the lesions encountered in the practice of surgery. These are illustrated with fresh material from the operating room, gross specimens from the museum and kodachrome and microprojected slides. The latest advances in blood grouping and transfusion reactions; didactic procedures, such as frozen sections, surgical biopsies, sponge biopsies, and aspiration of body fluid and secretions, are outlined.

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Cancer of the Breast

ENOCH CALLAWAY, M.D., LaGrange, Ga.

AT THE PRESENT TIME there exists a wide divergence of opinion concerning the proper treatment of cancer of the breast. There are those who advocate radical surgery in all cases and those who would depend entirely on radiation. Between these extremes can be found almost any number of combinations and variations of use of surgery and radiation. Since it is not possible in the limits of this article to discuss the relative merits of the different plans of treatment, the discussion will be limited to the choice of incision when radical surgery is carried out.

To select any of the numerous incisions which have been advocated for this operation and slavishly use it in all cases shows either a complete disregard for the basic principles of cancer surgery or absolute ignorance of the mode of dissemination of the disease. If we agree that nothing is accomplished by the removal of regional lymph nodes if extension of the disease in the subcutaneous tissue adjacent to the primary growth is left, we arrive at certain basic principles of technique which should never be violated.

Lymph channels from all parts of the breast converge at the nipple and also flow outward to the regional nodes, therefore the nipple should always be considered as one margin of the primary growth. The incision around the primary growth should always be at least three inches from its margins and from the nipple. The skin flaps should be dissected up thin according to the principles of Handley. Accessory incisions can be placed as needed to complete the radical operation.

If the basic principles described above are carried out it is easy to see that no one technique can be used in all cases. This technique will at times remove the skin from the axilla and necessitate the use of a mobilized plastic flap to cover the auxiliary structures. Defects at lower levels can be taken care of easily with split grafts.

If these principles are followed the resulting scar may not be beautiful but the incidence of local skin recurrences will be reduced tremendously. In all radical surgery for the cure of cancer, basic principles are of more importance than specific techniques.

Surgeons, Urologists, Anesthesiologists to Meet

The Annual Meeting of the Georgia Chapter of the American College of Surgeons with the Georgia Urological Society and the Georgia Society of Anesthesiologists will be held September 30-October 1, 1954, at the King and Prince Hotel, St. Simons Island, Ga. Speakers who have accepted the invitation to appear on the program are Willard H. Parsons, Chairman of the Board of Governors of the American College of Surgeons; John D. Stewart, Professor of Surgery, University of Buffalo; Samuel Marshall, Chairman of Surgery, Lahey Clinic, Boston; Nathan Womack, Professor of Surgery, University of North

Carolina; and Paul W. Hawley, Director of the ACS. Guest speaker for the Georgia Urological Society will be Hugh J. Jewett, Associate Professor of Urology, The Johns Hopkins University, Baltimore. The Anesthesiology speaker will be named later. Charles H. Watt, Thomasville, is president of the Georgia chapter of the American College of Surgeons; J. Robert Rinker, president of the Georgia Urological Society; and C. M. Westerfield, Savannah, president of the Georgia Society of Anesthesiologists. For hotel reservations write directly to the Manager, King and Prince Hotel, St. Simons Island, Ga.



BOOKS RECEIVED

Lipman, Bernard S. and Edward Massie, *Clinical Unipolar Electrocardiography*, Chicago, The Year Book Publishers, Inc., Second Edition, 1953, 309 Pages, bibliography, index, and illustrations. (no price listed)

Transactions of the American Ophthalmological Society, Eighty-Ninth Annual Meeting, Hot Springs, Virginia, 1953, V. LI, New York, Columbia University Press, 1954, 793 pages, index, illustrations. (no price listed)

Bacon, Harry E., and Stuart T. Ross, *Atlas of Operative Technic Anus, Rectum, and Colon*, St. Louis, The C. V. Mosby Company, 1954, 403 illustrations, index, 301 pages, \$13.50.

Neubuerger, Karl T., *Atlas of Histologic Diagnosis in Surgical Pathology*, with a section on *Exfoliative Cytology* by Walter T. Wickle, Baltimore, The Williams & Wilkins Company, 1951, Photography by Glenn E. Mills, \$11.00.

Wolstenholme, G.E.W., and Jessie S. Freeman, assisted by Joan Etherington, *Peripheral Circulation in Man*, Boston, Little, Brown and Company, 72 illustrations, 219 pages, index. \$6.00.

Recent Advances in Cardiovascular Physiology and Surgery, A symposium Presented by the Minnesota Heart Association and the University of Minnesota, September 14, 15, and 16, 1953, University of Minnesota, Minneapolis, Minn. 132 pages. (no price listed)

Galdston, Iago, *Beyond the Germ Theory*, New York, A New York Academy of Medicine Book, published by Health Education Council, 1954, 182 pages. (no price listed)

Abramson, Harold A., *Problems of Consciousness*, Transactions of the Fourth Conference, March 29, 30, and 31, 1953, The Josiah Macy, Jr. Foundation, New York, N. Y., 177 pages, \$3.25.

Senn, Milton J. E., *Problems of Infancy and Childhood*, Transactions of the Seventh Conference, March 23 and 24, 1953, The Josiah Macy, Jr. Foundation, New York, N.Y., 196 pages, \$2.75.

Ferrer, Irene M., *Cold Injury*, Transactions of the Second Conference, The Josiah Macy, Jr. Foundation, 242 pages, \$4.00.

Bradley, Stanley, *Renal Function*, Transactions of the Fourth Conference, October 22, 23, and 24, 1952, The Josiah Macy, Jr. Foundation, New York, N. Y., 189 pages, \$3.50.

Nachmansohn, David, *Nerve Impulse*, Transactions of the Fourth Conference, March 4, 5, and 6, 1953, The Josiah Macy, Jr. Foundation, New York, N. Y., 213 pages, \$4.25.

Shock, Nathan W., *Problems of Aging*, Transactions of the Fifteenth Conference, January 20, 21, and 22, 1953, The Josiah Macy, Jr. Foundation, New York, 213 pages, \$4.25.

Green, Harold D., *Shock and Circulatory Homeostasis*, Transactions of the Second Conference, October 19, 20, and 21, 1952, The Josiah Macy, Jr. Foundation, New York, N. Y., 275 pages, \$3.75.

Rifenstein, Edward C., Jr., *Metabolic Interrelations*, Transactions of the Fifth Conference, January 5 and 6, 1953, The Josiah Macy, Jr. Foundation, New York, N. Y., 386 pages, \$5.00.

The Family Health Maintenance Demonstration, A controlled long term investigation of family health, Milbank Memorial Fund, New York, 1954, 251 pages, \$2.00.

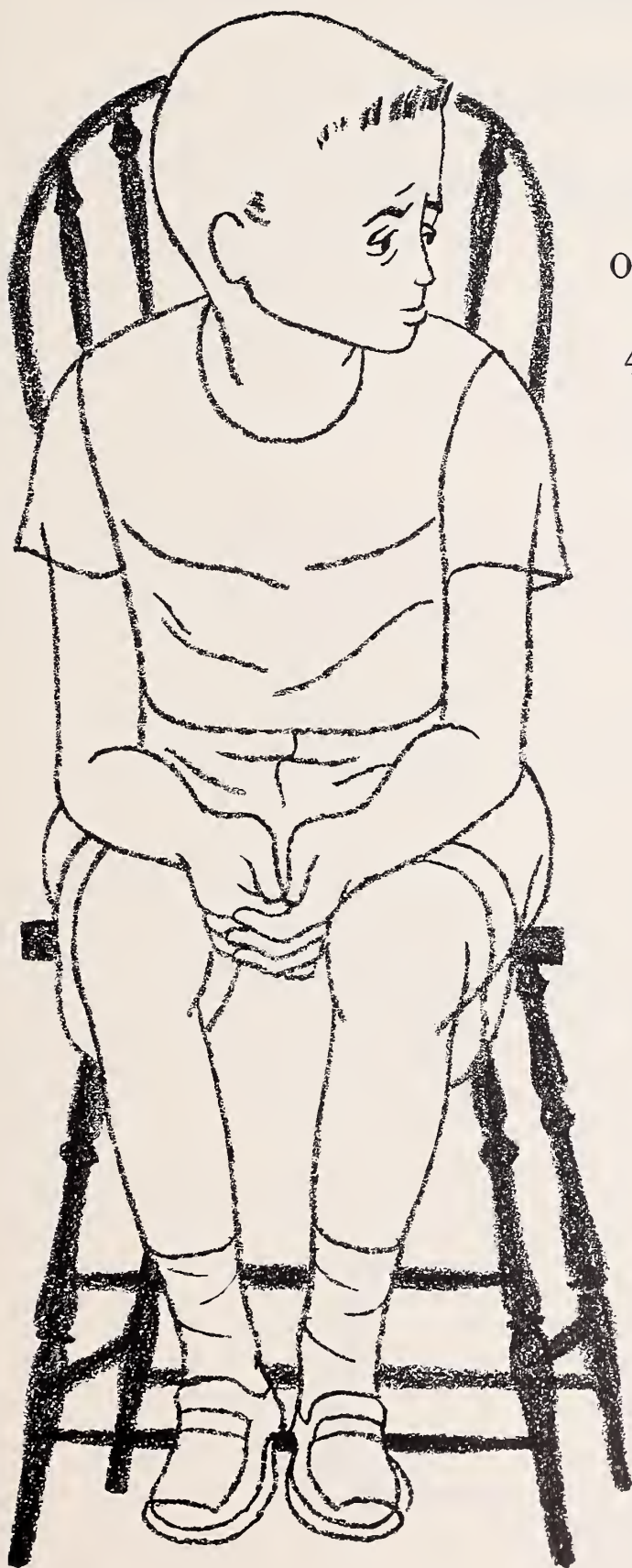
A.M.A. Fundamentals of Anesthesia, Philadelphia, W. B. Saunders Co., 279 pages, New (3rd) edition, 1954, \$6.00.

Hill, Fontaine S., *Practical Fluid Therapy in Pediatrics*, W. B. Saunders, Philadelphia, 1954, 275 pages, \$6.00.

Contributions to AMEF--1954

As of July 7, 1954, eleven contributions had been sent from Georgia to the American Medical Education Foundation. Those contributing are listed below: Emily B. Rogers, Atlanta; Worth County Woman's Auxiliary; Marion T. Benson,

Atlanta; Crisp County Woman's Auxiliary; Georgia Medical Society Woman's Auxiliary; A. P. Keller, Jr., Athens; Armen Bogosian, Ft. McPherson; Charles Eberhart, Atlanta; and Howard J. Morrison, Savannah.



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Schaerr, W. C., J. Missouri M. A., 37:287.

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AMA President Walter B. Martin, in his Inaugural Address of June 22, 1954, stated: "Medical Schools are in need of financial assistance. We are satisfied that federal aid to medical schools to meet operational costs introduces an element

of danger to the freedom of medical education that outweighs the need, however pressing that need may be. It is a particular responsibility of the physician in this country to aid in the financing of medical education. Few of us paid the full cost of our medical training at the time we received it. The debt is long past due, and each of us should make payments on this debt."

In spite of the fact that in 1953 the physicians in Georgia contributed only \$2,437.00, in this same year Emory University received \$21,947.00 and the Medical College of Georgia received \$22,380.00 from this fund.

When the request for contribution for this cause is made of you, it is your duty to give it your careful consideration and generous support.

Pathogenesis of Poliomyelitis

ANY ATTEMPT TO DISCUSS the pathogenesis of poliomyelitis at this time must be undertaken with the realization that new experimental data are rapidly accumulating which may alter our present concepts. The successful application of tissue culture techniques has greatly facilitated large scale studies of this disease and should yield much pertinent information within the next few years.

There is almost complete agreement that the virus multiplication occurs in the alimentary tract to-person contact and that it enters the body by way of the mouth. Man is the only known natural reservoir of the virus. The epidemiologic pattern is consistent with the passage of virus from person to person as a result of intimate contact chiefly in the home. It is currently held that primary virus multiplication occurs in the alimentary tract in paralytic as well as in silent infection. Although the virus may be recovered from the tongue, pharyngeal wall, and the large and small intestines, the greatest quantity of virus is found in the small intestine. The virus is only rarely found in the nose, and the characteristic lesions of poliomyelitis are not seen in the olfactory

bulbs in human poliomyelitis. Poliomyelitis virus has been recovered from feces up to 19 days prior to the onset of illness and persists in the feces for a few weeks to several months thereafter. It is not clear, however, whether oropharyngeal secretion or fecal material is the principal vehicle of spread of infection.

One of the most elusive problems in the pathogenesis of poliomyelitis has been the mode of passage of virus from the alimentary tract to the central nervous system. Earlier studies suggested that the virus passed from the alimentary tract by way of nerves and traveled centripetally up the axons to the central nervous system. Current investigations, however, have emphasized the importance of viremia as a necessary precursor to invasion of the central nervous system. Virus has been recovered from the blood of monkeys and chimpanzees within eight to 15 days after simple virus feeding and as early as five days before the onset of paralysis. In a few instances, virus has been recovered from the blood of human beings early in the course of the disease. The Failure to regularly demonstrate virus in the blood of human beings has been attributed to the high

levels of serum antibody, which is already present at the time of onset of paralysis. The new concept suggests, therefore, that virus is absorbed into the blood from the alimentary tract. The virus then apparently multiplies in the organs closely associated with the blood, initiating the rapid production of specific antibodies. The passage of virus from the blood stream into the central nervous system probably occurs during that brief period before sufficient antibodies are present to inactivate the virus in the blood. It is a curious fact, however, that paralytic poliomyelitis occurs in only a small per cent of individuals infected with the virus.

Various other factors are involved in the pathogenesis of poliomyelitis. Children are more susceptible to poliomyelitis than adults. This is presumably an expression of acquired immunity

due to widespread inapparent infections. However, there has been a shift in the age incidence of poliomyelitis in certain countries during recent years. In the United States, for example, about 25 per cent of the patients are now over 15 years of age. The highest incidence of the disease occurs in the summer and early fall. Fatigue, chilling and pregnancy appear to be predisposing factors. It has been demonstrated in experimental infection in monkeys that physical exhaustion or chilling during the incubation period increases the incidence and severity of paralysis. The more serious bulbar type of the disease may follow operative procedures about the nose and mouth. There seems to be little doubt that tonsillectomy performed during an epidemic period enhances the susceptibility to bulbar poliomyelitis.

William F. Friedewald, M.D

Electroencephalography

THE ANNOUNCEMENT in this issue of *The Journal* of the new Brain Wave Laboratory at St. Joseph's Infirmary represents not only another phase in current expansion of facilities in Atlanta's oldest and newest hospital but serves to emphasize the growing importance and use of clinical electroencephalography. Almost unknown except in highly specialized centers prior to World War II, EEG laboratories in the United States now number in the hundreds and there are more than 70 in the South. Other clinical laboratories in Georgia are at the University Hospital in Augusta and at Piedmont and Emory University Hospitals in Atlanta. Four large regional EEG societies and the American Electroencephalographic Society hold annual meetings for discussion of clinical and neurophysiological applications of the technique.

A review of theoretical and practical aspects of clinical EEG appeared in this journal in 1952 and no detailed repetition is needed. However, a recapitulation of salient features then presented and of subsequent developments may be helpful in relating the technique to everyday problems. The procedure consists of recording the electrical activity of the brain from the intact scalp by means of small electrodes which lead to vacuum tube amplifiers which drive ink-writing oscillographs. Recording is painless, without risk and can be done

on outpatients. Depending upon a variety of factors, from one to four hours may be required. The record is then analyzed visually for focal or general disturbances, epileptiform activity, and maturity and stability in relation to age. Because the data is not specific for disease entities the record must be made by the technician with knowledge of the presenting clinical problem and the findings related to it by the interpreting physician. For this reason, as Gibbs has recently pointed out, the value of the technique depends upon the experience and competence of both technician and electroencephalographer. The quality of work understandably varies widely.

The most extensive and successful use of the EEG has been in differential diagnosis and management of the epilepsies. In competent laboratories initial records of "idiopathic" and "symptomatic" epileptics are positive in some 50 to 60 per cent. This figure is increased with repeat records and the use of "activation" procedures such as sleep, intravenous Metrazol and photic stimulation. The last is now used routinely in many laboratories and consists of "driving" cerebral rhythms with a flashing light to reproduce certain types of cerebral seizure discharges during recording. When safe to do so, anticonvulsants should be stopped 48 hours prior to recording. The EEG may render decisive differen-

tiation between true seizures and functional disorders and malingering. In evaluation of seizure suspects the EEG has become an indispensable part of modern medical practice. The estimated figure of 17,500 epileptics in Georgia indicates how much is yet to be done in diagnosis and control in this field alone.

EEG location of supratentorial brain tumors now approaches 75 to 90 per cent accuracy with greater changes seen in the more rapidly growing neoplasms. Cerebral vascular lesions are located with somewhat less accuracy and best results are obtained when recordings are made early. Brain abscess, meningitis and meningo-encephalitis cause profound disturbances in the EEG. Many so-called "problem children" are found to have EEG abnormalities correlating with a history of encephalomyelitis after exanthematous or other infections. While the EEG has not been helpful in understanding neuroses and the "functional" psychoses it deserves much wider use in differential diagnosis in psychiatry in excluding other causes for behavioral disturbances. The EEG finds wide use in evaluating patients with

chronic headaches as an aid in excluding surgical conditions before instituting medical therapy. Conversely, those patients found to have functional headaches may be spared surgical procedures.

The growing medico-legal importance of electroencephalography has been recognized recently by a discussion of the subject in the Law-Science Institute sponsored last year by the Atlanta Bar Association and nationally by a symposium at the recent meeting of the American EEG Society. As an objective record of brain activity it is assuming legal status comparable to X-ray and cerebrospinal fluid findings in litigation where head injury is alleged. Serial records are of greater value than a single one for both clinical and medico-legal purposes since there is fair correlation between the EEG and clinical recovery after injury.

With these developments electroencephalography has passed from limited usage into nearly every field of clinical medicine. This growth may be expected to continue with increasing facilities and experience.

Licensure Standards

THE FOLLOWING RESOLUTION was introduced by State Board Medical Examiner Albert M. Deal, Statesboro, and adopted unanimously at the State Board of Medical Examiner's meeting, June 10, 1954.

"WHEREAS: in view of the criticism of the Board by the Medical Association of Georgia and other parties and in order that this Board may have a definite policy to guide its future action;

"BE IT RESOLVED: that effective this day, June 10, 1954, all applicants for licenses to practice medicine in Georgia be required to have received their qualifying medical degrees from a Class A Medical School of the United States or foreign countries, approved as such at the time of graduation, by the Council on Medical Education of the American Medical Association and/or the State Board of Medical Examiners of Georgia; and

"BE IT FURTHER RESOLVED: that the action taken by the Board at the meeting October 15, 1953, be amended to accept those otherwise

qualified applicants who successfully completed the National Board of Medical Examiners requirements and examination prior to October 15, 1953."

Action on this resolution was precipitated by incidents that cannot but reflect on the practice of medicine in the state of Georgia. Investigation showed that two applicants for Georgia Medical licensure were granted Georgia licenses in recent months even though they had graduated from what AMA termed less than a Class C medical school. The proverbial "barn door" is now closed, and only applicants who have graduated from AMA classified Class A schools will be accepted for Georgia licensure.

While the present State Board of Medical Examiners is not to be censured, need is shown for a closer liaison between the MAG and the Board. As in other states, this Board and other State Boards whose members are appointed by the Governor should be more closely controlled by MAG policy. The generally accepted procedure

is for the Medical Association of Georgia to submit to the Governor names of candidates to compose the boards. The Governor then chooses his appointees from the qualified and capable physicians recommended by the State Medical Association. This procedure is now followed in setting up the State Board of Health.

The Medical Association of Georgia's Council

and House of Delegates have repeatedly recommended that closer liaison be effected between the state boards and the Association. Surely the plan of having the MAG recommendations for the membership of these boards would insure this liaison. And it is reasonable to suppose that the Governor appointing these members would welcome MAG membership recommendations in choosing those physicians most qualified to serve.

Medical Ethics

FREQUENTLY AND TRULY it has been said that medical ethics are to be observed rather than enforced. Yet it cannot be denied that deviation from the ideal does occur and, on occasion, ethics must be enforced.

Medical ethics find their source in a "right conscience." They are a standard of conduct superior to custom or law. The observance of ethical principles by the physician elevates him and his profession to a commanding position of honor and respect in the eyes of mankind. Breach of the Principles of Medical Ethics, whether willful or accidental, lowers the physician from his respected position and reflects adversely on the profession.

When ethical principles are not observed, the

ethical physician has a positive duty to act appropriately to correct or have corrected such aberration of conduct. To be passive is to condone such conduct and to depreciate the principles against which offense has been made. The ethical physician individually and with his colleagues in his own community, where he and they have gained respect and have added to the dignity of the profession, must insure that no one through failure to observe ethical standards brings discredit to the profession or causes disservice to mankind. It is clear that this duty transcends individual consideration and demands that ethical physicians individually and collectively not tolerate within their numbers any who lack appreciation and understanding of the Principles and who do not scrupulously observe them.

Georgians Attend AMA Convention

The following is a list of the Georgia physicians, as they registered, who attended the San Francisco meeting of the American Medical Association in June: Eustace A. Allen, Atlanta; Carl C. Aven, Atlanta; Allen H. Bunce, Atlanta; Amey Chappell, Atlanta; Gerald R. Cooper, Chamblee; Claud M. Cupp, San Francisco; Edgar M. Dunstan, Atlanta; Spencer A. Kirkland, Atlanta; M. T. McGoogan, Jr., Waycross; Charles H. Richardson, Macon; Randolph Smith, Atlanta; Neal F. Yeomans, Waycross; Eli A. Rosen, Dalton; Jack E. Bell, Augusta; Thomas A. Harris, Atlanta; G. H. Schwab, Ft. Benning; W. H. Weddington, Marietta; Lester A. Brown, Jr., Atlanta; Benjamin Goldman, Hazelhurst; Joseph D. Gray,

Augusta; Robert B. Greenblatt, Augusta; B. T. Hickman, Alpharetta; Ted F. Leigh, Emory; Harold P. McDonald, Atlanta; Hamilton Murray, Atlanta; J. Victor Roule, Jr., Augusta; Trammell Starr, Dalton; John W. Turner, Atlanta; Jack Kelvin Bleich, Atlanta; T. J. Busey, Fayetteville; Ralph J. Davis, Rome; Slater M. Dozier, Ft. Benning; Major F. Fowler, Atlanta; R. E. Huie, Jr., Atlanta; Oliver W. Jenkins, Lindale; Thomas N. Pagg, Ft. McPherson; Henry H. Tift, Macon; J. H. Arnold, Newnan; Charles S. Britt, Brunswick; R. H. Brown, Atlanta; Owe Freese, San Leandro; David Henry Poer, Atlanta; Raymond A. Wonderlehr, Atlanta; Arthur J. Merrill, Atlanta; and John J. Barnes, Atlanta.

Gall Bladder Disease

THOMAS N. GUFFIN, M.D., and CHARLES S. JONES, M.D., Atlanta, Ga.

CHOLECYSTECTOMY CONTINUES to be one of the most frequently performed operations in general surgery. It follows closely behind hernia repair and appendectomy. As yet we do not understand the fundamental pathogenesis of gallstones and can do nothing to prevent their formation. As reported by Robertson and Dockett⁷ from postmortem statistics 32 per cent of women past 40 years of age have gallstones, while they occur in 16.2 per cent of men in this same age group. This indicates that operations on the gall bladder for stones will continue to occupy an important place in general surgery. This paper is an effort to study and report the elective cholecystectomies performed at Piedmont Hospital over a seven year period. Such a report can then be compared with the numerous papers appearing in the literature.

There were 293 operations performed on the gall bladder at Piedmont Hospital from January, 1947 to January, 1954. This represents one per cent of the 28,999 operations performed at Piedmont Hospital during the same period. Two hundred eighty-nine of these operations were cholecystectomies and four were cholecystotomies. The cholecystotomies and 19 of the cholecystectomies, a total of 23 cases, were performed for acute cholecystitis.

This report is primarily concerned with the remaining 270 operations performed for chronic disease of the gall bladder. Three of these cholecystectomies were performed in conjunction with other surgery. One gastrojejunostomy was performed for cholelithiasis and chronic duodenal ulcer; a diaphragmatic hernioplasty and cholecystectomy was performed once, and in the third case a duodenal diverticulum was excised. The only mortality in this entire series occurred in the last case.

Two hundred twelve females and 58 males were operated upon during this period representing 78.5 per cent and 21.5 per cent respectively.

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The youngest patient was 20 years of age, the oldest 83. The mean age of the group was 50 years.

Since the symptoms of gall bladder disease are, for practical purposes, often indistinguishable from those of many other diseases of the gastro-intestinal tract, organic and functional, we have accepted proof of diseased gall bladder by x-ray or laparotomy as the only criterion in determining the duration of disease. The duration of known diagnosis ranged from 21 years to one day. One hundred forty-five or 61.7 per cent were operated upon within six months of diagnosis. An additional 22, or 0.93 per cent, were operated upon within 12 months, and 68, or 28.9 per cent, over a period of 12 months. In the remaining 35 cases the date of diagnosis was not recorded.

In this series of 270 cholecystectomies, the common duct was explored in 16 instances, a percentage of 5.92. This low figure is in striking contrast to the number of common duct explorations usually reported.^{2 3 8}

Of these 16 common duct explorations 10, or 62.5 per cent were performed because of jaundice or recent history of jaundice. The remaining six were explored because of a history of biliary colic, dilated common bile duct, or questionable palpable stone in the common duct at the time of surgery. Stones were identified and removed from the common bile duct in six, or 37.5 per cent, of these explorations.

In two additional cases, at a later date following cholecystectomy, subsequent exploration of the common duct was performed and stones removed. In neither of these cases was the common duct explored at the time of original surgery. In one case, jaundice and biliary colic occurred one year following cholecystectomy. In the other case, intermittent attacks of biliary colic began two weeks after cholecystectomy. Exploration seven years later relieved the latter patient of a single common

An Analysis of 270 Cholecystectomies

duct stone. This case suggests that an individual may continue for many years without serious difficulty while harboring a common duct stone.

The indications for surgery in chronic disease of the gall bladder, aside from inconstant symptoms, was x-ray evidence of gall stones in 191 cases (81 per cent of the group). In 187 of these cases stones were found at surgery, representing an x-ray accuracy of 97.7 per cent. In 34 cases (14.6 per cent of the group) the gall bladder was non-functioning. The majority of this group had multiple dye concentration tests utilizing the double dose technique. Stones were found in 32, or 94.1 per cent of these gall bladders. Eight (3.5 per cent) cholecystectomies were performed following x-ray reports of "poor function." This term includes poor contrast, delayed emptying, and one case reported as deformity of the gall bladder. In only one case were stones found. The overall accuracy in x-ray diagnosis of gall stones was 97.3 per cent.

In 37 cases gall bladder series were either not done or not recorded in the patients' histories. Stones were found in 28 (80 per cent) of this group.

In 27 cholecystectomies (10 per cent of group) no stones were found at surgery. As outlined previously three of these had been reported as cholelithiasis by x-ray, three as non-function, and seven as poor function. Two additional cases revealed cholesterosis, two had had previous cholecystotomy, one had a previous attack of acute cholecystitis, and one an adenoma of the gall bladder. In six cases in which no stones were found, indications for cholecystectomy are unknown. There were no cases of carcinoma of the gall bladder in this series. Every specimen was submitted for pathological examination.

The average duration of hospitalization post-operatively was 10 days. The few complications that arose responded to appropriate therapy:

One feeding problem and prolonged vomiting in 73 year old female.

One biliary fistula following common duct exploration healed spontaneously.

Five pulmonary atelectases.

One wound disruption on 11th post-operative day.

One bleeding from skin requiring sutures.

There were no mortalities in the uncomplicated cholecystectomies or the common duct explorations. The one death in the series occurred in a 73 year old female who had a resection of a duodenal diverticulum and cholecystectomy as a combined procedure. Autopsy revealed a small area of necrosis in the distal one-third of the common duct with bile peritonitis. There was no pathology of the common duct at or near the ligated cystic duct.

The mortality for the total group is therefore 0.4 per cent. We feel that this is a significantly low percentage on which to base the premise that cholecystectomy is a lesser risk than the continued presence of stones in the gall bladder.

Discussion

In the foregoing analysis we have deliberately avoided a discussion of the symptomatology of gall bladder disease. These symptoms of vague epigastric discomfort, bloating and indigestion are often similar to those of carcinoma of the stomach, ulcer, allergies, irritable colon syndrome and gastro-intestinal neuroses.¹ Biliary colic alone is a reliable diagnostic symptom. The latter is also the only symptom for which the physician can offer reasonable assurance that the patient will be relieved. It is therefore obvious that cholecystectomy must offer more than relief of symptoms or the operation should be limited to a few selected cases.

It is our contention that gall stones, even of the silent type, constitute greater peril to the patient over a long period than the present risk of cholecystectomy. One hundred twenty-two cases of proven gall bladder disease who have not been subjected to surgery since the diagnosis was made are presently being studied. Early follow-ups indicate that a substantial number have encountered difficulties.

Twenty-nine per cent of the patients in this series had a delay of over 12 months from the time of diagnosis of gall stones to the time of surgery. Much of the delay was due to hesitancy on the part of the patient to undergo a major operation. Cholecystectomy in the absence of acute inflammation or common duct obstruction is certainly no emergency procedure, but a delay of years carries the patient into an older age group and increases the chance of a serious complication which may necessitate immediate surgery

at a much greater risk. It is the physician's responsibility to point out to the patient the greater risk of retaining his stones.

In the 34 cases in which the gall bladder was non-functioning, 94 per cent had gall stones at operation. This high degree of accuracy has been reported by many other observers.⁵ If the gall bladder cannot be visualized, and if the study is later repeated with the double dose technique and still cannot be visualized, the presence of stones may be assumed.¹⁻⁴ If the physician is satisfied that failure to visualize the gall bladder is not due to severe liver impairment or other associated disease, cholecystectomy should be carried out.

Zollinger and Hoerr⁶ have pointed out that the pitfalls of the non-functioning gall bladder can be avoided if the following facts are elicited:

- that the patient took the dye,
- that the patient did not vomit the dye,
- that the patient did not have gastric retention,
- that the patient did not have an attack of severe diarrhea.

Delayed emptying, poor contrast and deformity of the gall bladder are inconstant and insufficient indications of gall bladder disease. Often a gall bladder which concentrates poorly or empties slowly at one study may behave perfectly normally at a later date.²⁻⁵ Only in the presence of unequivocal biliary colic is cholecystectomy justified. Even then a careful survey of the entire gastro-intestinal tract should be made to exclude other pathology. The symptomatic results in these patients are poor.

The symptoms of biliary colic are usually clear. The pain is usually abrupt and severe in onset occurring in the epigastrium or right hypochondrium. Often the pain radiates to the tip of the scapula or the infrascapular region. It frequently occurs during the night and may waken the patient from sleep. Biliary colic may subside abruptly or gradually over a period of several hours.

The pain is usually of such severity as to require narcotics for relief. If the pain lasts more than several hours acute cholecystitis must be suspected.

In this series of cholecystectomies there was no standardization of procedure. The surgery was performed by various staff surgeons on their private patients. There was no uniformity in incision, method of dissection of the gall bladder, closure of the gall bladder bed or drainage. These do not appear to have been a significant factor in morbidity or mortality.

Summary

(1) Two hundred seventy elective cholecystectomies have been reported and analyzed.

(2) In 267 cases of cholecystectomy alone or combined with common duct exploration, there was no mortality.

(3) In the total series there was one death, a case of resection of a duodenal diverticulum with incidental cholecystectomy.

(4) In only 5.92 per cent of cases was it deemed necessary to explore the common duct. This is less than usually reported.

(5) We conclude that an elective cholecystectomy is safer for the patient than the potential complications of gallstone disease.

W. W. Orr Doctors Building

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3464 Ivy Rd., N. E., Atlanta, Ga. (Aug. 28, 1954); McGee, Jr., Harry H., 7 West Gordon St., Savannah, Ga. (Aug. 28, 1954); Pittard, Marion D., 1095 Blue Ridge Ave., Atlanta, Ga. (Aug. 31, 1954).

Treatment of Erythroblastosis Fetalis

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IN THE PAST FEW YEARS it has been noted by many observers that the mortality rate and the occurrence of kernicterus in erythroblastosis fetalis could be reduced by replacement transfusion.^{1 2 3} It is the primary purpose of this study to determine what effect replacement transfusion has had on the outcome of this disease in the Atlanta area. Several factors which might possibly influence the severity of the disease process and the occurrence of kernicterus have also been studied and will be discussed. These factors are the number of nucleated red blood cells in the peripheral smear, the initial degree of anemia, antibody studies on the infant's blood, serum bilirubin studies, and birth weight.

Material and Methods of Study

This study was made during the period from January 1948 through January 1954 at Crawford W. Long Memorial Hospital. The babies included in the series consisted primarily of those born to about 300 women who were studied in the Rh laboratory and in whose sera Rh antibodies were detected. A smaller group of affected infants who were transferred to the pediatrics service from other hospitals was also included. The cases studied were consecutive, and the only ones omitted were those which could not be followed. This study is unique in that most of the patients were private, and replacement transfusion was done at the discretion of the private physician. However, most of the patients were followed by the same clinical and laboratory methods and thus may be adequately compared.

The following laboratory studies were done on most of the infants in the series:

- (1) Complete blood count at birth and daily until stabilized.
- (2) Nucleated red blood cell count on peripheral blood at birth and daily until stabilized.

- (3) Rh antibody studies on cord blood, before and after replacement transfusion and daily until negative. These included:
 - (a) Test for red cell sensitivity (TCS). Two drops of the infant's blood and one drop of 30 per cent bovine albumen were mixed on a slide and observation for agglutination was made after four minutes on a pre-heated view box. A positive test indicated coating of the infant's cells with blocking antibodies.
 - (b) Direct Coombs test⁴ (DC) using the infant's cells.
 - (c) Indirect Coombs test (IC) on the infant's serum.
 - (d) Saline agglutination test using the infant's serum and trypsinized red blood cells (T).
 - (e) Slide albumen agglutination test (SAA) of Diamond and Abelson⁵ on the infant's serum.
 - (f) Rh type.
- (4) Serum bilirubin (indirect) on the cord blood and daily when possible. This was begun as a routine procedure in May 1952.

Our technique of doing replacement transfusion, which has been described previously,¹⁰ is a modification of the method described by Diamond et al² and Arnold and Alford.⁶ The umbilical or external saphenous route was used. Most of the infants were given a 500 cc. replacement, but 1000 cc. was used in a few cases.

All of the infants in this series have been followed in the Erythroblastosis Follow-up Clinic at Crawford W. Long Hospital or by their private physicians. These children have been observed for from four months to six years. A definite evaluation of their development was not made in most cases until at least six months of age. The occurrence of choreoathetosis, muscle rigidity, opisthotonus, convulsive seizures and mental retardation was considered evidence of brain damage (kernicterus). Post-mortem examination was done

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on practically all of the infants that died. The presence of yellow pigment in the basal nuclei was considered evidence of kernicterus.⁷

Observations

It has been a popular misconception that the severity of erythroblastosis fetalis could be determined at birth by clinical evaluation of the infant. This definitely has not been true in this study. However, many factors do indicate, to a certain extent, the expected prognosis. One of these factors is the number of nucleated RBC seen in the peripheral blood smear. This was observed in 168 infants with erythroblastosis fetalis (Table I). These cases were divided into three groups,

Table I—Relationship of Nucleated RBC/100 WBC to Severity of Disease

NucL RBC 100 WBC	No. Cases	Mild		Moderate		Severe		Deaths		Kernicterus	
		No.	%	No.	%	No.	%	No.	%	No.	%
0-20	92	47	51.1	33	35.8	12	13.1	4	4.3	3	3.2
21-100	43	5	11.7	20	46.6	18	41.7	6	13.9	5	11.6
+ 101	33	1	3.1	3	9.1	29	87.8	10	30.3	3	9.9

based on the number of nucleated RBC/100 WBC. It is apparent that about one half the infants with 0-20 nucleated RBC/100 WBC were only mildly affected. The mortality rate in this group was only 4.3 per cent, and kernicterus occurred in only 3.2 per cent of the cases. This is to be compared with the group in which 21-100 nucleated RBC/100 WBC were seen. The severity of the disease is worse in this group and the mortality rate is 13.9 per cent. Kernicterus occurred in 11.6 per cent of these infants. In the group in which nucleated RBC were seen in numbers greater than 101/100 WBC (the highest was 1600/100 WBC) the severity of the disease was markedly increased. There was only one infant that was mildly affected whereas 87.8 per cent were severely affected. The mortality rate in this group was 30.3 per cent. Kernicterus occurred in 9.9 per cent of the cases which is not significantly different from the second group. The treatment in these cases varied. Some of them received replacement transfusions and some did not. From these observations it is apparent that a small number of nucleated RBC frequently indicated a good prognosis, but some babies also became severely diseased and developed kernicterus or died. When there was a high nucleated RBC count, however, the prognosis was almost always grave and the mortality rate and occurrence of kernicterus was high. (Figure I).

Many clinicians have used the initial degree of anemia manifested by these infants as an indication of the severity of the disease. This has been an extremely unreliable factor in this series. Of 25 infants that were severely affected and died but did not show evidence of kernicterus at post mortem examination, there was only one with a red blood count above four million, five with red counts between two and four million, and 19 with red counts below two million. The primary cause of death in these infants was anemia. On the other hand, there were 13 infants who were severely affected and developed kernicterus (Table II). Six of these lived and seven of them died. It is apparent that this group was not as anemic as the previous group. Five of these infants had red cell counts above four million. Only one had a red cell count lower than two million, and none had red cell counts less than one million. Thus many infants who developed kernicterus had only a slight to moderate degree of anemia at birth, and it was distinctly unusual to see kernicterus develop in the severely anemic infants (red cell count less than two million). This observation might lead one to think that the reason the severely anemic infants did not develop kernicterus was because they died of anemia before kernicterus could develop. This might have been true in some

Table II—Factors Influencing Occurrence of Kernicterus

Case No.	Initial RBC	Blood Count Hb	Bilirubin mg%	Weight, Lb.-oz.	NucL RBC 100 WBC	Treatment	Outcome
27	4.9	15.7		5-4	1	T-3**	L K
21	3.6	10.9		6-10		T-1	L K
6	3.2	11.3		6-9	65	T-4	L K
22	2.6	7.4		6-11	47	T-2	D K
28	4.8	16.6		8-11	32	T-2	D K
56	4.3	13.5		6-14	37	T-1	D K
50	2.4	7.9		7-12	55	None	D K
67	2.7	11.7		5-15	3	T-1	D K
169	1.2	5.5	29.2	4-9		RT 14 h*	L K
200	2.8	10.3	49.0	6-4	379	RT 35 h	L K
84	4.1	14.0		7-2	660	RT 33 h	L K
181	2.9	9.0	34.0	3-11	374	RT 19 h	D K
162	4.4	13.0		6-4	13	RT 10 h	D K

**small blood transfusion, three
*replacement transfussion, age 14 hours

of the cases but there were 20 infants who had initial red cell counts between two and three million and eight infants with red cell counts less than two million who did not die or develop kernicterus.

In the majority of the cases in which maternal antibodies had been detected in the laboratory,

routine antibody studies were done on the cord blood or on blood drawn from the infant. Several different patterns were noted (Table III).

Table III—Relationship of Infant Antibody Studies to Severity of Disease

Diagnosis	No. Cases	TCS % plus	DC % plus	IC % plus	T % plus	SAA % plus
Normal Rh Pos.	20	14	6	0	6	0
Normal Rh Neg.	26	4	0	64	47	56
I. G., mild	66	72	90	27	18	43
I. G., moderate	64	96	96	58	48	57
I. G., severe	61	100	98	69	57	65

TCS, test for cell sensitivity; DC, direct Coombs; IC, indirect Coombs; T, trypsin agglutination test; SAA, slide albumen agglutination test; I. G., icterus gravis.

(1) Normal Rh positive infants. There were 20 normal Rh positive infants born to mothers who had laboratory evidence of iso-immunization. Most of these mothers had low albumen titers (1:16 or less). Apparently these infants had stimulated some degree of maternal iso-immunization, in most cases mild, but the antibodies had failed to pass back into the fetus in great enough quantity to cause blood destruction. Of the 20 infants, 17 showed no evidence of antibodies detected by any of the five tests used, i.e., TCS, DC, IC, Trypsin and SAA. The TCS was positive in two instances, the DC in one instance and the Trypsin test in one instance. No clinical or other laboratory evidence of disease could be detected in any of these cases. Thus the majority of normal Rh positive infants born to immunized mothers will have no evidence of antibodies in their own blood (Figure II).

(2) There were 26 normal Rh negative infants. Many of these mothers ran extremely high titers, three as high as 1:1024. As noted in Table III, one infant had a positive TCS but this was probably a laboratory error since Rh negative cells theoretically cannot be coated with blocking antibodies. None of these infants had a positive

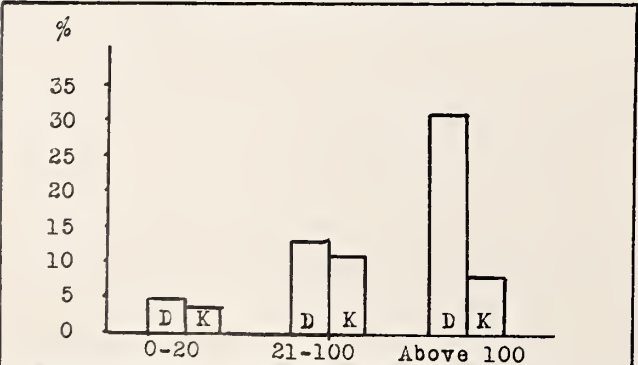


Fig. I Relationship of Nucleated RBC to Mort. Rate and Occurrence of Kernicterus

DC. The IC, T, and SAA showed a high percentage of positive reactions indicating a passive transfer of circulating antibodies into the fetal circulation due to the high maternal titers. These antibodies were unable, however, to affect the infant's cells. Thus when the infant is Rh negative, the TCS and DC are negative but the other tests may be positive or negative and are diagnostically insignificant (Figure II).

(3) There were 191 liveborn infants with erythroblastosis fetalis in whom antibody studies were made. These infants were divided into three groups (Table III) depending upon the severity of the disease. The TCS and DC were not uniformly as sensitive in the mild cases as they were in the severe cases. Only one of the mild cases showed both a negative TCS and DC. None of the moderately severe or severe cases showed both a negative TCS and DC. Thus both tests are done routinely and in 99.4 per cent of the cases of erythroblastosis fetalis, regardless of severity, one or both tests have been positive. The progressive increase in sensitivity of the IC, T and SAA with the increase in severity of the disease is apparently related to increased amount of maternal antibody seen in the more severe cases and is a manifestation of a passive transfer of this antibody to the infant.

In 137 of the above infants at least four of the five previously mentioned antibody tests were done. Four of the five tests were positive in 20 per cent of the mildly affected infants (45 cases), 59 per cent of the moderate to severely affected infants (92 cases) and in 73 per cent of the infants who died or developed kernicterus. Thus a positive reaction to at least four of the five antibody tests usually indicates a severe prognosis. Eighty-five per cent of the infants who showed this antibody pattern were moderately to severely affected, and there were 11 cases in this group

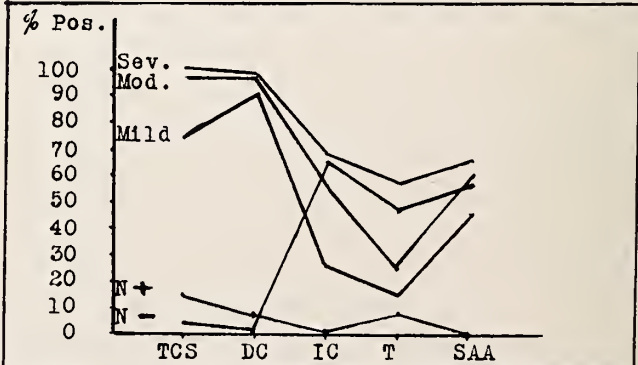


Fig. II Relationship of Infant Antibody Studies to Severity of Disease

which resulted in death or kernicterus or both.

Unfortunately we did not begin serum bilirubin studies until May 1952, so on many of our cases that developed kernicterus we did not have this information. Bilirubin studies were done on 82 affected infants. As can be seen in Table IV, no

Table IV—Relationship of Serum Bilirubin Level to Occurrence of Kernicterus

Bilirubin Level mg%	No. Cases	Kernicterus	
		No.	%
Less than 10.0	21	0	0.0
10.1 — 20.0	27	0	0.0
20.1 — 30.0	18	1	5.5
30.1 — 40.0	13	1	7.7
Above 40.0	3	1	33.3

cases of kernicterus occurred in the group of cases in which the serum bilirubin remained under 20.0 mg. per cent. There was in each of the groups one case which showed bilirubin values of 20.1-30.0 mg. per cent, 30.1-40.0 mg. per cent, and above 40.0 mg. per cent. Thus the three cases of kernicterus that occurred in the cases studied were in the groups whose bilirubin values were above 20.0 mg. per cent. These three infants were treated with replacement transfusion late in their illnesses. These observations have been noted by others⁸ who have a larger series of cases. From our limited studies it seems apparent that the height of the serum bilirubin is directly related to the occurrence of kernicterus.

It has been said by other observers^{9, 3, 1} that kernicterus is most often seen in premature infants (birth weight less than five pounds eight ounces). In this series (Table II) only three of the 13 infants with kernicterus were premature by weight. However if all the infants studied are divided into two groups according to weight, it is noted that 12 per cent of the premature infants (three of 25) developed kernicterus, whereas only 5.3 per cent of the full term infants (10 of 189) showed evidence of brain damage. Thus in this series, kernicterus occurred a little more than twice as often in the premature infants.

Comparison of Methods of Treatment

Eighty-six liveborn infants with laboratory and clinical evidence of erythroblastosis fetalis were observed and not treated with replacement transfusion. There were several reasons why replacement therapy was not used. About one-third of this group occurred before replacement transfusions were done at Crawford W. Long Memorial Hospital. The remainder were treated without replacement transfusion by preference of the private physician. In seven cases replacement transfusion

was begun but the infant died before the procedure could be completed. Four infants in this group died because of reasons other than erythroblastosis fetalis (congenital heart disease, aspiration of amniotic fluid and prematurity). Most of the infants in this group were treated with small blood transfusions. Some received no treatment. Forty-three per cent of the infants in this group were classified as having a mild degree of the disease. Of the 86 infants in this group 25 died (Table V). This is a mortality rate of 29 per

Table V—Effect of Replacement Transfusion on Mortality Rate and Occurrence of Kernicterus

Treatment	No. Cases	Deaths		Kernicterus	
		No.	%	No.	%
No R. T.	86	25	29.0	8	9.3
R. T. after 8 hrs.	35	2	5.6	5	14.2

cent. There were eight cases of kernicterus in this group (9.3 per cent). Only one of these infants was premature by weight..

One hundred twenty-eight infants with clinical and laboratory evidence of erythroblastosis fetalis were treated with replacement transfusion. The replacement transfusions were done at various intervals of time after birth. When the disease was anticipated because of maternal antibodies during pregnancy, clinical observation was more thorough, and laboratory studies were done on the infant's blood as soon as possible after delivery. Twenty-six per cent of the cases in this group were mild. Two deaths in this group could not be attributed to erythroblastosis fetalis but were directly due to congenital anomalies. The infants that were treated by replacement transfusion were divided into two groups according to the age at which the replacement transfusion was done (Table V). One group of 35 infants had replacement transfusions which were started between 10 and 63 hours after birth. In this group there were two deaths (5.6 per cent, and five cases of kernicterus (14.2 per cent). The other group of 93 infants had replacement transfusions started within eight hours after birth. In this group there were five deaths (5.3 per cent) and no cases of kernicterus. Thus it is apparent that the mortality rate was the same regardless of when the replacement transfusion was carried out. The mortality rate in the group not treated with replacement transfusion was more than five times as great. The occurrence of kernicterus, however, dropped from 14.2 per cent in the group given replacement therapy late to 9.3 per cent in the group that did not receive replacement therapy, and to zero in

the group that received replacement transfusion therapy early.

An effort to maintain the serum bilirubin below 20 per cent was made in babies treated with replacement transfusion, and this necessitated two or three procedures in many cases.

Summary

1. Several factors that influence the severity of erythroblastosis fetalis were studied:

(a) A high nucleated RBC count in the infant's peripheral smear usually indicated a severe course. In those infants who showed zero to 20 nucleated RBC/100 WBC the mortality rate was 4.3 per cent and kernicterus occurred in 3.2 per cent. In those infants whose nucleated RBC counts were high (over 100/100 WBC) the mortality rate was 30.3 per cent and kernicterus occurred in 9.9 per cent.

(b) Most of the infants who died but did not have kernicterus had moderate to low red blood cell counts at birth. Many of the infants who developed kernicterus, however, had moderate to high red blood cell counts at birth.

(c) Five antibody tests (TCS, DC, IC, T, SAA) were done on a number of infants born to immunized mothers. The normal Rh positive infants usually showed no evidence of Rh antibodies. Most of the normal Rh negative infants had a negative TCS and DC, indicating that their cells were not coated with blocking antibodies, but many of them had circulating antibodies passively transferred from the mother as evidenced by positive IC, T and SAA. The infants that had erythroblastosis fetalis usually had a positive TCS and DC, and in all but one case they showed a positive reaction to at least one of these two tests, indicating that the cells were coated. These tests increased in sensitivity with the severity of the disease. The tests for circulating antibodies (IC, T, SAA) also increased in sensitivity with the severity of the disease. In 85 per cent of the cases with at least four of the five antibody tests positive, the course of the disease was severe.

(d) No kernicterus occurred in the infants whose bilirubin levels remained below 20 mg. per cent. Kernicterus occurred in 8.8 per cent of the infants with levels higher than 20 mg. per cent.

(e) Only three of the 13 infants with kernicterus were premature by weight, but 12 per cent of the premature infants developed kernicterus, whereas only 5.3 per cent of the larger infants showed signs of brain damage.

2. A mortality rate of 29 per cent and a kernicterus rate of 9.3 per cent occurred in 86 erythroblastotic infants not treated with replacement transfusion. In the group (35) treated with replacement transfusion later than eight hours after birth the mortality rate was much lower, 5.6 per cent, but kernicterus occurred in 14.2 per cent. Ninety-three infants were treated with replacement transfusion within eight hours after birth with a resulting mortality rate of 5.3 per cent. No kernicterus occurred in this group.

Conclusions

In addition to the clinical appearance of the infant many laboratory tests such as blood counts, nucleated RBC count in peripheral smear, and the presence of Rh antibodies in the infant's blood help to indicate the severity of the disease. These tests do not always give an accurate prognostic picture, however. The serum bilirubin level is apparently a good method of predicting a disease severe enough to result in kernicterus, and this level should be kept below 20 mg. per cent. Unless serum bilirubin levels can be done at intervals of at least every 12 hours, it seems advisable to treat all infants with laboratory evidence of antibody-coated red blood cells with replacement transfusion. It is important that the procedure be done early, within eight hours after birth, since the mortality rate is very low and kernicterus has not been seen in this group.

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Sarcoma of the Larynx

Review of Literature and Addition of a New Case

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SARCOMA OF THE larynx once was regarded as a not uncommon tumor, but it has been shown more recently to be rare. This change has probably come about because of improved pathological interpretation. For this reason, widely divergent views are encountered regarding its incidence. Forty-eight cases of laryngeal sarcoma were reported through 1882 by Bosworth and 99 cases through 1897 by Bergeat, but the histology of these early cases is open to question. Ewing points out that many cases reported as sarcoma of the larynx are probably of epithelial origin. Of 643 neoplasms of the larynx reviewed by Jackson in 1929, there was not one true sarcoma. Thompson and Colledge reported from London in 1930 that in their wide experience they had not seen a single sarcoma of the larynx. In 1933 Figi reviewed the laryngeal malignancies at Mayo Clinic from 1910 to 1933 and found 713 carcinomas and only four sarcomas. In 1941 Havens and Parkhill reviewed the literature for the previous 30 years and found 15 cases of sarcoma of the larynx of which 10 were fibrosarcomas (there may have been some repetition of cases in this series). Rigby and Hollinger in 1943 reported a case of laryngeal sarcoma in a 17-day old white male infant. Glick in 1944 described a sarcoma in the larynx of a 10-year-old white male.

The etiology of sarcoma of the larynx is undetermined. However, the following general characteristics may be attributed to laryngeal sarcomas: 1. they are most often primary in the true vocal cords; 2. usually the tumor is pedunculated and lobulated; 3. ulceration of the tumor surface is not usual; 4. laryngeal sarcomas tend to be more localized and less infiltrating than laryngeal carcinomas; 5. metastases from laryngeal sarcomas are longer delayed than from laryngeal

carcinomas; 6. most laryngeal sarcomas occur in patients over 40 years of age (range 17 days to 74 years); 7. laryngeal sarcomas are more frequent in males by a ratio of 3:1.

The symptoms produced by laryngeal sarcoma are referable to mechanical interference with function and depend on the size and situation of the tumor. Hoarseness is usually the first symptom produced. Dyspnea and dysphagia often follow. Absence of cervical node enlargement in the presence of a large, seemingly malignant tumor of the larynx is clinically suggestive of a sarcoma in this location. Positive diagnosis is established with biopsy and microscopic section. Repeat biopsies are often required.

Treatment of laryngeal sarcoma may be either surgical or radiologic. A small growth may be removed intralaryngially and the base cauterized with the cold cautery. Larger lesions are best treated by laryngofissure or laryngectomy. Radiation is usually reserved for inoperable cases or as an adjunct to surgery. The first, permanent relief following laryngectomy was reported by Baltine in 1876 with the patient known to be in good health three years following operation.

Prognosis depends on the extent of the growth, the activity of the tumor and the method of treatment applicable in any given case. In 47 cases reported by Bosworth, the average life expectancy was 19 months after onset of symptoms. However, all of those cases were treated prior to 1892. By contrast, Figi described in 1933 the results of treatment of four cases of laryngeal sarcoma; three were living 96 months, 86 months, and 24 months respectively after onset of laryngeal symptoms. The other patient died of influenza 28 months after onset of laryngeal symptoms and was probably free of laryngeal disease at the time of death.

Case Report

A 24-year-old white male electrician was admitted to the Otolaryngology Section of the V.A.

From the Dept. of Otolaryngology of the Lawson Veterans Administration Hospital, Chamblee, Ga.

hospital, Chamblee, Georgia, on April 9, 1949, complaining of a swelling in the left side of the neck with a sore throat of one month's duration. He had seen several general medical doctors who prescribed gargles and penicillin. The patient became progressively worse and developed dysphagia and hoarseness. He went from his home in South Carolina to Kansas City, Missouri, to begin school, but his condition became so troublesome that he visited an otolaryngologist in Kansas City, who found a mass occupying the left pyriform fossa and aryepiglottic fold. It was apparently thought that the mass was an abscess and digital rupture was attempted. Failing to achieve success with that method, the physician hospitalized the patient and biopsied the mass with a tonsil snare removing a piece the size of a "pigeon egg." A section of the tissue was examined microscopically, and the patient was forthwith transferred to the V.A. Hospital, Chamblee, Georgia, for treatment.

Past History

The patient was treated for "thyroid trouble" in 1942 with "thyroid pills." About this time he had lymph nodes of the right axilla removed followed by x-ray treatment to the area. He was told that the nodes were tubercular. A node had been incised in the right side of the neck at the age of eight months. He had a left mastoidectomy at the age of twelve. Tonsillectomy was performed at seven years of age.

Physical Exam

The patient was a young well nourished and developed white male who spoke in a hoarse voice. There was a questionable soft tissue mass in the left neck just above the level of the thyroid gland. Mirror examination of the larynx revealed a mass one inch in diameter occupying the left aryepiglottic fold, the left false vocal cord and the left pyriform fossa. The true vocal cords appeared to move well and were not involved. There was considerable swelling about the left arytenoid cartilage.

The heart and lungs were negative. Blood pressure 120/80. There was a scar in the right axillary area. The remainder of the physical examination was negative.

An x-ray of the lungs was negative. Kahn and urine examinations were negative. Blood count revealed 6,450 WBC with 60 per cent polymorphonuclear cells and 13.8 grams of hemoglobin.

Microscopic sections of the biopsy material obtained in Kansas City were sent to Lawson V.A. Hospital with the patient, but no definite diagnosis could be made. On April 19, 1949, a direct laryn-

gосcopy was carried out under general anesthesia using sodium pentothal and curare in an attempt to determine the extent of the tumor and to obtain a biopsy. During the operation the patient developed respiratory difficulty, and a tracheotomy was performed. The tumor was found to involve the left side of the larynx and to have a moderately broad base. There was swelling of the entire left larynx, except for the true vocal cord which did not seem involved. Biopsies were taken from the tumor mass which was friable and bled easily.

Microscopic sections were obtained, and the pathology report described a fibrosarcoma. The patient was then seen by the Tumor Board of Lawson V.A. Hospital which suggested a trial of x-ray therapy, and if the tumor proved not to be radio-sensitive, surgery was to be used. After a few x-ray treatments, it was apparent that the tumor was very radio-sensitive, and, following the administration of 3,850 Roentgens, no visible mass could be seen on mirror examination. A total of 7,450 Roentgens was given, and at the termination of treatment all signs of a tumor had disappeared. His general condition was likewise greatly improved at this time. Despite the excellent result, it was felt that the prognosis should be guarded. He was discharged from the hospital on July 19, 1949. He was followed at monthly intervals, and it was not until December of 1950 that a swelling in the left side of his neck was noted. This swelling was not accompanied by symptoms. Examination revealed a rubbery mass at the level of the larynx anterior to the sternocleidomastoid muscle. On mirror examination a cystic-appearing mass was seen arising in the left pyriform sinus and thought to be attached to the larynx. On February 12, 1951, an exploration of the neck was carried out; a tumor mass was found arising through the cricothyroid muscles. Removal of this mass was not possible; however, a biopsy was taken and once again was reported as fibro-sarcoma. On March 6 a tracheotomy was necessary to insure an adequate airway. On March 13 direct laryngoscopic examination was performed with the use of Lynch suspension, and a considerable amount of necrotic tissue was removed from the left pyriform sinus. During this period of hospitalization, the patient received 4,500 Roentgens, this amount being thought to be sufficient in view of the prior therapy. The airway improved to such an extent that the tracheotomy tube could be removed; however, on May 29 he

suddenly developed acute respiratory distress and an emergency tracheotomy was performed. During the subsequent weeks, a marked dysphagia developed, and by June 16 he was unable to swallow liquids. A gastrostomy was performed on that date. Despite the length and extensive treatment it was felt that surgical intervention offered this man his only hope, and, in view of the fact that considerable general improvement followed the instigation of the tube feedings, a radical dissection of the neck was carried out on July 31. All of the strap muscles, the upper trachea, the larynx, the glottis, and the upper esophagus were removed. The larynx had been destroyed almost entirely as had the left lobe of the thyroid. The left carotid sheath was invaded by the necrotic mass, and the internal jugular vein on this side was thrombosed. On the right side, the carotid sheath and phrenic nerve remained. The immediate post-operative course was satisfactory; however, on the fourth day following surgery the suture-line began to separate and this was followed by an extensive breakdown of almost the entire

operative site. On August 7 there was a sudden massive hemorrhage through the neck wound which ceased spontaneously after a few moments. Three hours later, a second massive hemorrhage occurred, and all attempts at control were unavailing. Death occurred within a matter of moments. The hemorrhage was observed to come from a rupture of the left common carotid artery.

Summary

The literature of sarcoma of the larynx has been reviewed and a new case presented.

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New Skin Eruption

An outbreak of a new, mild illness, characterized by a skin eruption, is described in the June 5 *Journal of the American Medical Association*.

The disease, prevalent in and around Boston in 1951, was found to be both infectious and contagious, according to three physicians who made a study of 18 cases and reported 2,450 cases seen by other physicians.

Although the condition had some of the features of German measles, careful study showed that it is probably an entirely new type of infection, the report stated.

The 18 patients studied by the physicians ranged in age from four months to 26 years. The majority of patients had a fever of about 102F which lasted one to two days and was accompanied by a sore throat, a generalized aching of muscles, and chills.

All the children, but only one of the three adults afflicted, exhibited varying degrees of skin

eruption. The rash usually was most evident over the face and upper chest, appearing in most cases after onset of the other symptoms and within one or two days after the fever had subsided. Some of the patients suffered mucous membrane lesions and enlargement of their neck glands. None, however, appeared severely ill. Multiple cases appeared in two families.

A questionnaire regarding the new disease was sent to physicians in Massachusetts, the authors said. The 123 physicians who replied stated they had seen about 2,450 such cases between May and September, 1951. According to the replies, the epidemic eruptive disease affected primarily children 10 years of age or younger and was characterized by fever and a skin rash that appeared either during fever or after it had subsided. Fever and the rash lasted at least 24 hours in most cases, and in many cases lesions of the throat were apparent. Multiple cases were not uncommon in a single family.

Resumption of Activity

Following Poliomyelitis

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THE RESUMPTION OF neuromuscular activity is the most beneficial and, at the same time, the most dangerous aspect of the modern treatment of the aftereffects of acute anterior poliomyelitis. Modern treatment of this disease is based upon a careful balance between activity and rest. Activity is necessary for the recovery of strength and for the prevention of musculoskeletal deformities, but activity must be based on an accurate knowledge of existing muscle strength, coordination and endurance. Haphazard activity, or prescribed activity not based on precise muscle analysis are the major causes of limited recovery and the development and/or progression of musculoskeletal deformities. Activity is usually thought of as movement of bodily segments with changing tension in muscles and motion in joints. But activity does not necessarily imply movement. Activity should be thought of as any stress within or upon bodily segments from movement or position. Walking is certainly an activity but so is standing. Sitting upright in a chair or even moving about in bed may be just as hazardous for the severely involved patient as running or jumping would be for the mildly involved. Activity, so defined, becomes a highly relative term. If modern treatment is the prescribed balance between activity and rest, prescription for treatment can be no better than the physician's ability to precisely and accurately determine muscle strength. This determination must be made not only through individual muscle testing, but through analysis of varied bodily movements requiring the interaction of many muscles. No machine has ever been devised to make this test for the physician. Even after such a thorough analysis, a responsible prescription for care can-

not be written unless the physician is aware of the dangers and limitations as well as the necessity for activity.

This necessity for activity is easily understood for there can be no dispute that strength, coordination and endurance can never be recovered by keeping the patient motionless in bed. However, in the very simplicity of this fact lie the dangers of overactivity. It is too easy to believe that if a little activity is good, more must be better. To the patient the dangers of physical overactivity are at least three: (1) structural distortion of involved bodily segments; (2) faulty patterns of bodily movement; (3) loss of muscle strength.

Structural deformities, or distortion of bone, and contractures about joints will occur eventually even in normal individuals if the bodily segments are placed repeatedly in faulty position. The muscular weakness that follows poliomyelitis and the demineralization that occurs with disuse and inactivity permit rapid changes in the contour of bone and mobility about joints. These faulty positions resulting in persistent abnormal stress may occur during rest or activity. Thus, while prescribed activity is necessary for prevention of deformity, overactivity can cause or accelerate deformity. It is for this reason that corsets, braces, splints and crutches may be necessary in the early phase of recovery if a patient's own muscles are too weak to support activity. Such supportive apparatus permits and encourages early safe activity and must be thought of as a part of the overall treatment essential to recovery. Such support is to be discarded as soon as recovery of strength occurs in the patient's own muscles and he becomes strong enough to maintain proper alinement of bone and joint. The failure to prescribe, obtain and use properly fitted functional apparatus early in the recovery phase is a major fault in treatment.

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Faulty patterns of movement may be even more dangerous than faulty positions of rest. Poliomyelitis tends to involve entire bodily segments, that is of forearm and hand, or of shoulder girdle and arm, or the hip and thigh, or the leg and foot, or the trunk. Within these segments all muscles tend to be weakened to some extent, and there appears to be a definite relationship between the degree of initial involvement and eventual recovery of a muscle and its normal amount of innervation. Those muscles, such as the anterior tibial, opponens pollicis and abductor brevis pollicis, which have a limited normal innervation, frequently are most severely involved and are slow and limited in their recovery. It is reasonable to believe that, after the first two or three months following the acute stage, all motor units not actually killed by the invasion of the virus have recovered, and the anatomic pattern of the future is settled. The purpose of treatment is to efficiently use all of these remaining motor units. The goal of treatment is for the patient to recover the ability to carry out normal activities even though he is left with less than normal numbers of motor units. In order to attain this objective, each muscle fiber must be hypertrophied for maximum strength, and each nerve pathway supplying impulses to these muscle fibers must be coordinated to the efficiency of the trained athlete. Unfortunately, all muscles do not recover strength simultaneously. Some have certain positional and reflex advantages and thus recover more rapidly. If patients are permitted unlimited activity during the period of expected recovery, movements are attempted only with those muscle groups that are stronger and under some voluntary control. This results in abnormal or substitution patterns of movement that are not only inefficient, awkward and fatiguing, but also are patterns that ignore the weaker groups which cannot take part in the activity. As these movements are repeated they become habitual and are difficult, or even impossible, to break even though the unused groups recover physiological excitability. If intact motor units are not used, or are used inefficiently, maximum recovery is not possible. Certainly, no athlete ever needed a wise coach as much as these patients, and for the same purpose.

Perhaps the greatest danger of overactivity lies in overwork of recovering muscles. Too few physicians appreciate the damaging effects of persistent overwork of the neuromuscular

system even in the normal individual. Overwork of muscles, particularly when coupled with faulty patterns of motion, is the most frequent cause of incomplete recovery as well as actual loss of strength following poliomyelitis. On the basis of clinical experience over many years there is infinite proof of this, and no one who has had the opportunity to follow his patients with accurate muscle tests can fail to realize this. In the laboratory, repeated overwork of specific muscle groups can be shown to be the cause of prolonged and even irreversable loss of strength. In our early studies of neuromuscular fatigue at Warm Springs Foundation, we unknowingly caused loss of strength in a few biceps muscles which today, over four years later, have not recovered the strength they had when we started our experiment. Safe grading of muscular exercise to develop increasing strength and endurance is not simple. It must be based on repeated analysis of muscle action during movements of bodily segments against varying resistance. Certainly, it should be a basic principle in treatment that muscle groups must never be encouraged to repeatedly bear stresses beyond their strength to hold. Occasional and very brief periods of overloading a muscle as a part of testing will usually be without danger.

This paper would not be complete without a brief discussion of the timing of a few of the common activities desired by the patient and necessary to his recovery. It must be kept in mind that any activity can be started and should be started as soon as it can be started safely. To be safe, an activity must neither endanger skeletal alignment nor muscular recovery. This is true regardless of the stage of the disease, whether it be acute, convalescent or chronic.

(1) Use of hands: It must be realized that a patient will use his hands whether the physician desires him to or not. Faulty patterns of use develop quickly in the hands. It is important that weaknesses in hands, particularly weaknesses of intrinsic musculature, be determined early and functional splinting applied immediately. Ideally, such a hand splint should not only support bone, joint and muscle, but also permit satisfactory use of remaining muscle strength. The very fact that good hand splints are difficult to obtain is an indication of the physician's failure to see the need for such splints. If the physicians would recognize and demand adequate splinting, the brace makers would supply the need.

(2) Sitting upright: We usually think of sitting in its relationship to alignment of the spine. Correct alignment of the spine is highly important, particularly in children. But equally important are the stresses placed upon the intrinsic musculature of the spine, the extrinsic muscles of the trunk, particularly the abdominals, the posterolateral muscles of the hip and all musculature of the shoulder girdle. Sitting also tends to promote hip flexion contractures, knee flexion contractures and equinus positions of the feet. Sitting should be started shortly after the acute stage is over while maintaining due regard for the dangers outlined above. Anteroposterior X-rays of the sitting spine should be taken as soon as the patient can sit upright and be repeated every two to four months in children until full bone growth has occurred. If a corset or back brace is used, the spine should be X-rayed with the support in place to determine whether the support is actually maintaining good alignment of the spine, or simply covering up faulty alignment.

(3) Standing: Both sitting and standing are necessary to promote proprioceptive reflexes essential to the activation of intact motor units. Standing should be started as early as may be done. Standing is far more dangerous than sitting because of the stress of body weight on trunk and lower extremities. If crutches, corset or braces are necessary to good posture and safe standing, they should be used. The dangers of standing will be directly related to the design and fit of such apparatus. Even the very severely involved patient, who will never walk safely or practically, should be gotten into the standing position for reasons both psychological and functional. Most patients should begin standing within the first

three months, the only exceptions being in the very young child or in critical medical problems.

(4) Walking: walking is obviously more hazardous than standing but it is essential to recovery. Whether a patient will walk safely and with grace and endurance will depend not only upon his muscle power but also on his early training in standing and the basic patterns of locomotion. Rarely should walking be delayed beyond six months except, as mentioned above, in the very young or in critical medical problems. The ability to move about safely and practically will lead to the more strenuous activities of returning to school, to work, and to forms of recreation. All are important to maximum recovery, but each carries the constant dangers of overactivity; it must remain the responsibility of the physician to direct wisely.

In conclusion, it should be restated that modern treatment of the sequelae of poliomyelitis requires a delicate balance between activity and rest. There are hazards in too much or too little of either. Rest is essential for recovery, but recovery can never take place without activity. Activity inexpertly prescribed may cause musculoskeletal deformities, inefficient muscular action, delayed recovery or even loss of strength.

Georgia Warm Springs Foundation

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Polio Vaccine Evaluation

More than 600,000 children have completed three inoculations in the field test of the trial polio vaccine developed by Dr. Jonas E. Salk of the University of Pittsburgh. The emphasis now shifts to the evaluation study under the direction of Dr. Thomas Francis, Jr., University of Michigan School of Public Health. The validity of the evaluation is dependent upon data gathered on poliomyelitis cases in the test groups, *including those children in the first three grades who did*

not get vaccine.

In addition, data on cases among family members of participating children are an integral part of the study. Since the number of poliomyelitis cases among the test groups may not be large, it is essential that all cases are completely reported. Early diagnosis, prompt reporting and follow-up, and the securing of *necessary epidemiological information and laboratory specimens are important factors in the evaluation.*

The Necessity for a Will

MR. HARVEY HILL, Atlanta, Ga.

A WILL IS PROBABLY THE most important document a person will ever execute, because it disposes of all the property he has accumulated during his lifetime.

A will is not a contract—it is changeable—something that can be revised or even destroyed at any time. It never takes effect until death. Therefore, it should be kept current, not only to take advantage of favorable changes in the tax laws and other laws, but also to meet the present wishes of the testator for the distribution of his estate.

Why is it necessary to make a will?

To answer this question, let's first see what happens to the estate of a man with a wife and two minor children, who fails to make a will and dies intestate, a resident of Georgia. An administrator is appointed to handle his estate. The administrator may be some person absolutely unknown to the decedent. It could be a creditor of his estate. The appointment of the administrator is entirely in the hands of the court. Upon appointment the administrator must furnish bond in double the amount of the personal property of the estate. He must file an inventory as well as an appraisal and must make periodic returns, all of which is very costly to the estate. The administrator has absolutely no discretion in the handling of the estate. He must apply to the court for leave to make any sale; he cannot borrow money for estate purposes. In fact, he must petition the court for authority to take any and all action needed in the proper administration of the estate.

The property of the decedent is distributed according to the Georgia laws of descent and distribution, which means that the property would be distributed in three equal parts among the wife and two minor children.

A guardian must be appointed for each child to receive his share of the estate. The mother of the children would be the logical appointee. The appointment would require court action, and the guardian would be required to make bond in double the value of the personal property of the shares of the children distributed to the guardian. The guardian must hold the share of each child until that child attains the age of 21 years and during that period must invest the property strictly according to the investment laws for guardians in Georgia. Furthermore, the guardian must keep books and records, make annual returns to the court, and like the administrator must petition the court for authority to do all things connected with the guardianship. The entire operation, as you can see, is quite tedious and very expensive.

Thus, if you fail to make a will the legislature of our state will step in and make one for you, and the one the legislature makes might not be suitable at all. It is almost impossible for the laws of our State to direct the distribution of an estate and have the property reach the intended parties or distributed to the intended parties in the manner desired by the decedent.

Now, let's suppose the same man makes a will and dies testate, a resident of Georgia. Who administers his estate?

An executor of his choosing is appointed to handle his estate. This is one of the most important decisions he must make, because the administration of estates today has become a highly specialized job which requires experienced and competent management.

A testator wants an executor who has had long experience with tax problems—one well qualified to protect the rights of his estate and avoid overpayment of taxes—one who will use thoroughness in listing every item of property to assure proper accounting—one who will exercise prudence and sound business judgment in settling debts and will use the most effective methods of raising cash to

Read before the General Session on Legal and Financial Problems at the 104th Annual Session of the Medical Association of Georgia, Macon, May 4, 1954.

pay them, and one who has a thorough knowledge of all phases of estate settlement and performs these tasks in the best interest of the beneficiaries—one who will distribute the various items of testator's estate fairly and impartially and will take a sincere personal interest in the problems of his beneficiaries.

Any executor so appointed should be trusted to the extent of being relieved from making bond, filing inventory and appraisals and returns to the court. Furthermore, he should be given full power and authority to make private sales and to make investments at his discretion, free of limitations and without any order of court. In other words, if the testator thinks enough of him to appoint him executor, he should give him free reins to administer his estate. A good executor can save many dollars in the proper administration of an estate that otherwise might be wasted.

He can make specific bequests to individuals such as his aged parents, or to charities, which he could not do without a will.

The smart thing for the testator to do would be to create by the terms of his will a trust for his wife and children. This would be convenient for his wife, protect the principal of his estate, and the testator would be reasonably assured of financial security for his family.

If his estate exceeds \$60,000 in value, he could use the much talked of marital deduction trust authorized under the Revenue Act of 1948. This provides that the husband or wife may give to the other by will, one-half of his or her estate, free of estate tax. In general, the property may be given (1) in fee simple, (2) in trust to receive all income for life with a general power of appointment, and (3) in trust with remainder to the estate of the surviving spouse. This use of the marital deduction trust might save his estate large

sums of money in federal estate taxes.

One thing more—aside from the will—most doctors today are financially successful. Their incomes are substantial, which means they are in high surtax brackets. With the income tax laws as they are, it's very difficult for a doctor to retain much of his earnings. Therefore, consideration should be given by him to the new gift tax laws, which offer considerable relief if properly applied.

The Revenue Act of 1948 made important changes with regard to gifts. Each person is allowed to give away during his or her life, property valued at \$30,000, and, in addition, may make annual gifts of \$3,000 each to any person or persons. The husband and wife may make joint gifts of \$6,000 annually to any person although the gift may be from the property of one spouse. In the same manner a husband or wife may give to the other a sum of money or property and only one-half of the amount of such gift will be considered as a gift; the other half, as a result of the community property concept, being considered the property of the recipient. Gift of \$60,000 to wife by husband would be considered as gift of \$30,000 and no gift tax would be payable provided the husband had not exhausted his specific life time exemption of \$30,000, or the husband or wife may give the other \$6,000 in any one year, which in view of the community property concept will be considered as a \$3,000 gift and will not be taxable.

A man can save his estate in taxes the earnings of a life time if he would but take time out from his work long enough to give careful consideration and intelligent study to the course he wishes his family to follow after his death and actually do something about it.

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Life Expectancy Jumps Four Years

Average length of life in the United States has reached a record high of 68 and one-half years, a gain of nearly four years in the past decade, according to vital statistics compiled by the U. S. Public Health Service of the Department of Health, Education, and Welfare.

Women on the average outlive men by six years. The average lifetime expected for women at birth is 71.8 years, while the average for men is 65.9 years. This difference in the life expectancies of men and women has increased sharply since 1900 when females outlived males by an average of only two years.

Amebiasis¹ a "Poorly Reported" Disease

*Until serious complications arise,
amebiasis may pass unrecognized and
patients receive only symptomatic treatment.*

Although amebiasis is a disease with serious morbidity and mortality, statistics on its incidence¹ are incomplete because its manifestations are not commonly recognized and consequently not reported.

"Vague symptoms² referable to the gastrointestinal tract, such as indigestion or indefinite abdominal pains, with or without abnormally formed stools, may result from intestinal amebiasis. Not infrequently in cases in which such symptoms are ascribed to psychoneurosis after extensive x-ray studies have been carried out, complete relief is obtained with antiamebic therapy."

To prevent possible development of an incapacitating or even fatal illness and to eliminate a reservoir of infection in the community, diagnosing and treating³ even seemingly healthy "carriers" and those having mild symptoms of amebiasis is advised.

Early diagnosis¹ is important because infection can be rapidly and completely cleared, with the proper choice of drugs and due consideration for the principles of therapy. For treatment of the bowel phase these authors find Diodoquin "most satisfactory."

For chronic amebic infections, Goodwin⁴ finds Diodoquin to be one of the best drugs at present available.

Diodoquin, which does not inconvenience the patient or interfere with his normal activities, may be used in the treatment of acute or latent forms of amebiasis. If extraintestinal lesions require the use of emetine, Diodoquin may be administered concurrently. It is a well tolerated and relatively nontoxic orally administered amebicide, containing 63.9 per cent of iodine.

Diodoquin (diiodohydroxyquinoline), available in 10-grain (650 mg.) tablets, reduces the course of treatment to twenty days (three tablets daily). Treatment may be repeated or prolonged without



Endamoeba histolytica (trophozoite).

serious toxic effect. It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. G. D. Searle & Co., Research in the Service of Medicine.

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abstracts by georgia authors

Mason, T. H., Capt. M.C.; Swain, G. M., Capt. M.C.; Osheroff, Col. M.C., Camp Gordon, Ga. "Bilateral Carotid-Cavernous Fistula", *J. Neurosurg.* 11:323-326 (May) 1954.

A patient who had sustained a head injury developed bilateral proptosis and bruits over both orbits. A carotid thrill was palpated on the right and the bruit was diminished by compression of the right carotid artery. Angiography disclosed a right carotid-cavernous fistula. The left angiogram appeared normal. The right internal carotid artery was ligated and the bruit was diminished on the right and was intensified over the left orbit. A left carotid thrill then developed. The right carotid artery was clipped in the supraclinoid portion through a right frontal craniotomy. The bruit was less on the right but still louder on the left. A second left carotid angiogram was performed and disclosed another carotid-cavernous communication on the left. The left internal carotid artery was ligated, and the bruit over the left orbit decreased. Left external angiogram showed filling of the cavernous sinus by retrograde flow through the ophthalmic artery. The left common carotid artery was ligated. A faint left bruit was audible until about two months following the last surgical procedure. Patient withstood all of these procedures very well and had only the original bilateral sixth nerve palsies which were noted prior to onset of severe proptosis. There was some loss of sensation over the trigeminal nerve on the left. Surgical treatment of bilateral carotid-cavernous fistula was dictated by repeated angiographic studies.

Nemcik, Frank J., Lt. M.C.; Franklin, Edward C., Lt. M.C.; Camp Gordon, Ga. "Shoulder Dysfunction in Pulmonary Tuberculosis", *Am. J. Med. Sciences* 227:601-608 (June) 1954.

A group of 260 patients hospitalized for the treatment of pulmonary tuberculosis was surveyed in order to determine the frequency of shoulder disabilities and to evaluate factors responsible for their development.

It was found that the incidence of limitation of motion of the shoulder was low under the age of 40 (1.6 per cent), but was high in patients over 40 years of age (24.2 per cent).

Shoulder symptoms invariably developed while the patient was at complete or almost complete bed rest, although they frequently persisted after his activities had increased. In most instances symptoms developed during the first six months of bed rest. None of the other factors studied was found to influence the onset of shoulder dysfunction.

Since disuse of the upper extremity is postulated to be one of the more important factors in the development of shoulder disability, it is suggested that a program of shoulder exercises be instituted for patients over 40 years of age who are hospitalized for the treatment of pulmonary tuberculosis, in order to prevent the occurrence of this complication and to treat it vigorously and rapidly if it should develop in spite of this.

Olansky, Sidney; Harris, Mr. Ad; Casey, Miss Helen; Public Health Service; Chamblee, Ga. "Immune-Adherence Test for Syphilis", *Pub. Health Reports* 69:521-526 (June) 1954.

A reaction between human erythrocytes and treponemes sensitized by antibody from syphilitic serum was first described by R. A. Nelson, Jr. Since this immune-adherence reaction (or IA) is technically much simpler than the TPI test it would be a desirable substitute for the TPI test if found to be equally efficient. This study compares the TPI, IA, and the VDRL Slide test. The findings show that the pattern of reactivity of the IA test more closely follows the TPI test than that of the VDRL Slide test. Since the anti-

bodies that produce positive reactions in the TPI and the VDRL Slide test are known to be different, the substance producing such reactions in the IA test is probably similar to, if not identical with, the substance that activates the TPI test. Since the IA test is a simple, rapid laboratory procedure, and since antigen for this test need not be freshly prepared, this test may be a practical substitute technique for detecting the TPI test antibody.

Murray, Hamil, Emory University School of Medicine. "A Modified Cytological Technique for the Detection of Uterine Carcinoma", *Cancer* 7:519-521 (May) 1954.

A technique is described which decreases the time required in the collection, preparation, and screening of vaginal smears. It combines certain advantages of the gelfoam sponge biopsy, the "surface biopsy", and the conventional smear.

The technique consists of obtaining material from the cervical os with a cotton applicator which has been dipped in collodion and allowed to dry. The applicator is placed immediately in a test tube containing ether-alcohol fixative where it remains for 15 minutes. The collodion dissolves, leaving a suspension of fixed cells in the solution of collodion and fixative. The cells settle to the bottom of the tube requiring no centrifugation. A small amount of sediment is taken up in a cellophane pipette and placed on a slide. The fixative evaporates leaving the cells and cell clusters imbedded in a film of collodion. This preparation is stained and screened as any other smear. There is abundant material left in the test tube for preparation of additional slides if indicated.

One hundred swab preparations and 100 conventional smears were taken simultaneously from normal women and from patients having known uterine carcinoma. The information obtained from the swab preparations agreed with that obtained from the conventional smears, except that in one instance diagnostic material was present in the swab preparation but not in the smear. The time required for the procedure is approximately one-half that for the conventional smear, and the method is particularly applicable to routine screening of large numbers of patients in clinics or hospitals.

Schoof, H. F., & Siverly, R. E., CDC, Public Health Service, Atlanta, Ga. "Urban Fly Dispersion Studies with Special Reference to Movement Pattern of *Musca Domestica*", *Am. J. Trop. Med. & Hyg.* 3:537-547 (May) 1954.

At Phoenix, Arizona, approximately 147,000 radioactive *Musca domestica* were liberated, at a primary release site. For the 2-day period following, 15 fly traps were operated at three secondary sites one-half mile from the primary release point; the flies collected at each secondary site were then dusted with a characteristic dye, after which they were again liberated.

Collection stations within one mile of the primary release point indicated that, even though fly dispersion from that site followed a general random design, one sector of the recovery zone yielded a higher rate of recapture of radioactive specimens than the remaining sectors.

A total of 104 radioactive and dyed *M. domestica* was retrieved. Fly movement from each of the three secondary release sites exhibited a random pattern. Reciprocal migration was manifested, certain specimens reversing their initial path of migration and returning to the general area of the primary release site.

The data indicate *M. domestica* to be essentially an insect of migrating habits. The house fly apparently spends the greater part of its existence in moving from site to site not only in search of breeding and feeding sources but also from an inherent instinct to wander.

Chambers, William R., Doctors Bldg., Atlanta, Ga. "That Fatal First Twenty-four Hours in Head Injury", GP 9:35-39 (June) 1954.

Approximately 30,000 deaths from head injury occur in the United States every year, and the number is growing. More than half occur away from large medical centers and must be cared for solely by the general practitioner. Forty-five per cent of the deaths occur in the first 24 hours, so that the patient's chance for life depends heavily on the skill and generalship of the original treatment. Rules of treatment in order of importance are as follows:

Management—First 6 Hours

1. Airway
2. Shock
3. Hemostasis—simple
4. Rest
5. Find other injuries—treat simply—look in orifices
6. Observation
7. Restraint—no sedation
8. Prevent complications—get the history
9. Treat as an emergency.

The airway is most important. Anoxia may destroy or permanently impair the injured brain in minutes. Rules for its care are as follows:

Airway

1. Position—never face up
2. Keep tongue forward—look for obstructing foreign bodies
3. Aspiration—bronchoscopy
4. Tracheotomy early where necessary
5. Postural drainage if tolerated

Shock is the second consideration, and may be considered as follows:

Shock

1. Picture the Pathology
2. Double Strength Plasma
3. Serum Albumin
4. Intra-arterial Blood Transfusion
5. Hypertonic glucose—sucrose
6. Oxygen
7. Apply bandage to Abdomen and Extremities
8. Spare the fluids—save the patient
9. Salt is contraindicated

Methods of applying the other principles of management are also given, and rules for gauging the seriousness of the case.

Chambers, William R., Doctors Bldg., Atlanta, Ga. "Intraspinal Tumor, a Difficult Diagnosis", Am. J. Surg. 87:824-827 (June) 1954.

Intraspinal tumor may masquerade as multiple sclerosis, atrophic lateral sclerosis, postero-lateral sclerosis, arterio-sclerosis of the nervous system, poliomyelitis, peripheral neuritis, and "spinal syphilis". Remissions characterize benign spinal tumors, and so closely simulate multiple sclerosis that Bucy advises that "any patient over 35 who develops such symptoms be investigated for tumor".

Rule of thumb diagnosis is dangerous, as a tumor may almost exactly reproduce those symptom complexes generally taught as pathognomic of certain diseases of the nervous system, depending upon the position of the tumor. An instance of a patient who could not walk without watching her feet, and was therefore treated for one year as tabes dorsalis, is cited. A meningioma, pressing on the posterior columns, was responsible. Radicular pain and positive Queckenstedt need not be present. There is no substitute for a thorough neurological exam, complete X-rays of the spine, and spinal tap.

Goldman, Morris, CDC, Lab Branch, Box 185, Chamblee, Ga. "Use of Fluorescein-Tagged Antibody to Identify Cultures of *Endamoeba histolytica* and *Endamoeba coli*", Am. J. Hyg. 59:318-325 (May) 1954.

Antiserum of *Endamoeba coli* was prepared in rabbits by subcutaneous inoculations of washed culture sediments containing intact amebae. The globulin fraction of this antiserum was separated and conjugated to fluorescein. Control experiments demonstrated that bright fluorescence observed in amebae exposed to tagged homologous antiserum was due

to a specific immunochemical reaction. The use of tagged antiserum to *E. coli* and *Endamoeba histolytica* made it possible to identify correctly the species of amebae occurring in stock cultures submitted as unknowns for testing by this method. "Small race *E. histolytica*," *Dientamoeba fragilis*, *Endotimax nana*, and *Endamoeba invadens* were readily distinguished from *E. histolytica* and *E. coli* by use of tagged antiserum. Some implications of these results and limitations of the fluorescent antibody technique are discussed briefly.

Gucker, Thomas III, Warm Springs, Ga. "What Can We Do About Polio—1954?", J. Kentucky State Med. Ass'n. 52:413-416 (June) 1954.

Since 1954 marks the first large-scale trial of vaccination against polio, certain facts are especially pertinent. Polio seems to be spread principally by prolonged intimate contact. There are three known immune-specific types of virus capable of producing paralysis in man. Most adults, especially in urban areas, have circulating antibody for at least one type. Gamma globulin can produce short-lived passive immunity with a high degree of protection but not when used for household family contacts. Up to 1.9 million doses will be available by August 31st for use throughout the country. In predetermined areas a carefully triple-tested formalin killed vaccine has been given to around half a million children between six and nine years of age. The use of G. G. in these areas is undesirable since the evaluation of the effects of the vaccine will not be possible until some time in 1955. Meanwhile, certain general preventive measures are still important; namely: avoid intimate contact with strangers; defer tonsillectomy and adenoidectomy during an epidemic; prevent chilling and fatigue; during a polio outbreak insist on bed rest until all uncertainty is past.

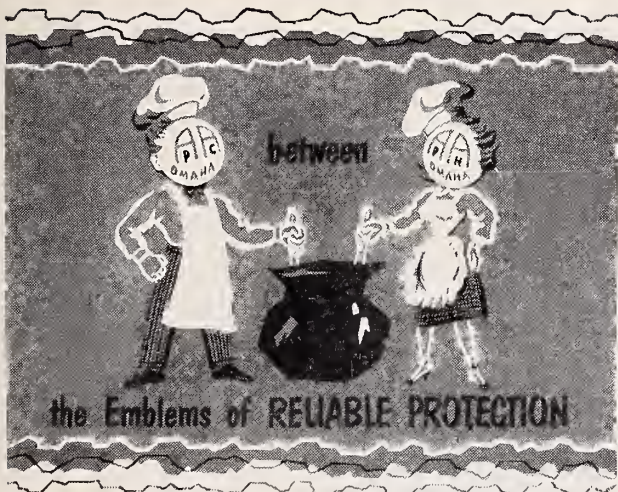
Petrie, Lester M.; McLoughlin, Chris J.; Hodgins, Thomas E., 12 Capitol Sq. S. E., Atlanta, Ga. "Mass Screening for Lowered Glucose Tolerance", Ann. of Int. Med. 40:963-967 (May) 1954.

The results of mass screening for lowered glucose tolerance by age, sex and race of 241,457 persons surveyed are given. Glucose tolerance tests were administered to all suspects. These individuals were classified as normal, abnormal and borderline on the basis of criteria as defined in the paper. The correlation between urine and blood sugar findings is briefly discussed. The prevalence of lowered glucose tolerance in the population tested increased almost on a straight line with the increase in age, with the highest incidence of 7.38 per cent in those over 70 years of age. There was a definitely higher prevalence of lowered glucose tolerance in the Negro female than in the Negro male, or the white male or female groups.

Skobba, Joseph S. "Military Psychiatry—Review of Progress in 1953," American Journal of Psychiatry 110:537-539 (Jan.) 1954.

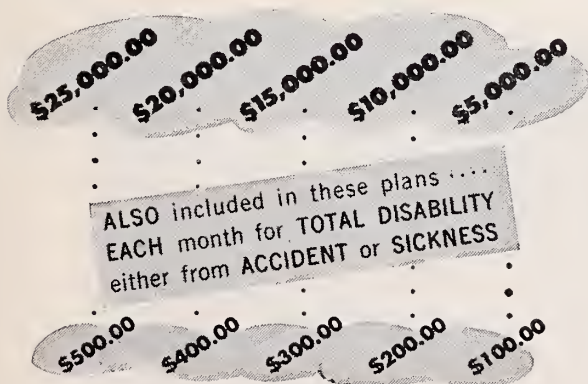
Military psychiatrists report that the functions of the division psychiatrist have been extended from treatment and evaluation to prevention by periodic visits to battalions and divisional units to aid in the psychiatric orientation of the units and indoctrination talks to the officers. Non convulsive electroshock therapy was found of little practical value in the early phases of combat breakdown. Individuals who show marked disorganization and confusion even though recovering quickly should not be returned to combat. The term "death anxiety neurosis" was suggested as more clearly representing the reaction than operational fatigue or combat exhaustion. Studies of the relationship of age to resistance under military stress suggest that men 18-19 years old are the most emotionally fit to resist the various stresses of military service and that through the age of 38 there is no suggestion that any particular age is critical. It was found that the aim of the screening procedure to identify and reject every individual with a psychoneurotic vulnerability was in error and it is suggested that studies of the stresses which have no counterpart in civilian life be made. Group psychotherapy with psychoses with stress on return to duty even though resulting in longer periods of hospitalization for some than traditionally acceptable resulted in a marked reduction in transfers and separations. The expansion of outpatient treatment facilities was very effective in reducing the population of open wards.

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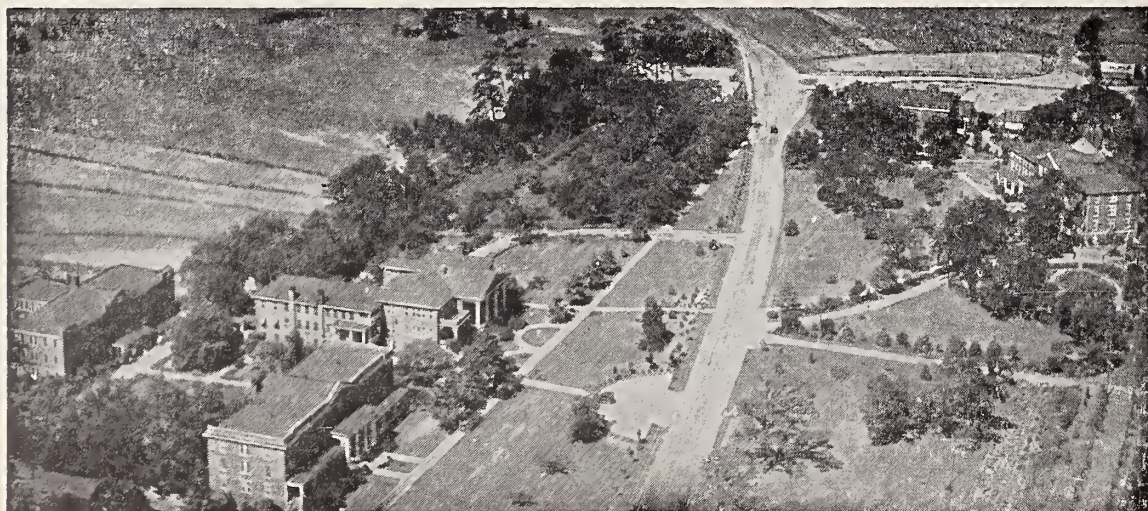
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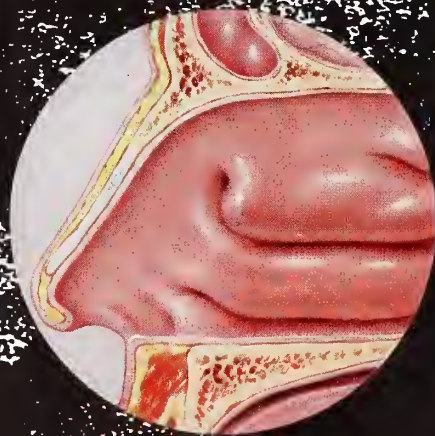
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9-city study
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Pyribenzamine[®]

in ragweed hay fever

In the summer and fall of 1953, nine prominent allergists, representing every section of the country except the West Coast, tested Pyribenzamine in a total of 832 patients with ragweed hay fever. The work of these men is significant because of its scope and because it is the most recent major study of antihistamines.

Certain observations are particularly worth noting ... →



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THE ALLERGIC PATIENT... before and one-half hour after receiving PYRIBENZAMINE



**... of the 832 patients who were
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C I B A



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to the
periphery
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Priscoline®

Increases blood flow to the extremities through a direct vasodilating effect on vessel wall, a sympathetic blocking effect, and an adrenolytic effect—

A valuable aid in the treatment of peripheral ischemia and its sequelae—pain, loss of function, ulceration, gangrene, and other trophic manifestations—

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**BILATERAL
ARTERIOSCLEROTIC
ULCERATION** in patient age 65.

At start of Priscoline therapy;
ulcer, right leg, $1\frac{3}{4}'' \times 1\frac{1}{4}''$;

ulcer, left leg, $\frac{1}{2}'' \times \frac{1}{2}''$.

With oral Priscoline, 25 mg. four times daily for one week and 25 mg. every three hours thereafter, there was marked improvement in 2 weeks and healing within 6 weeks. No other medication given.



**HYPERTENSIVE ISCHEMIC
ULCER** of right leg in patient

age 65. Ulceration refractory to treatment for 9 months, with patient complaining of severe pain. Treated with oral Priscoline, 50 mg. four times daily for four days and 50 mg. every four hours thereafter. Healing began with onset of Priscoline therapy and was complete in 10 weeks.

PHOTOGRAPHS AND CLINICAL DATA
BY COURTESY OF R. I. LOWENBERG, M.D.,
CONSULTANT IN VASCULAR SURGERY,
CONNECTICUT STATE HOSPITAL,
MIDDLETOWN, CONNECTICUT.

C I B A



doctor placement page

AVAILABLE PHYSICIANS

Berry, Reginald V., M.D., US Naval Hospital, Pensacola, Florida, age 47, married, Protestant, graduate Yale Medical School, 1932, residency Duke University, North Carolina; U. S. Naval Medical Center, Maryland, interested in psychiatry and neurology in Georgia (clinic, assistant associate or institutional), available July-August 1954.

Coleman, Julian B., M.D., US Naval Air Facility, Weeksville, Elizabeth City, North Carolina, age 33, single, Protestant, graduate McGill University, 1952, priority 4, size of community not important, in clinic or as an assistant or associate, available July 15, 1954.

Fitz, Thomas E., M.D., 1053 Oakland Avenue, Rock Hill, South Carolina, age 32, married, 3 children, Presbyterian, graduate Duke University School of Medicine, 1949, specialty—internal medicine and cardiology presently in practice, wishes to relocate due to economic status, desires group or associate practice, available two or three weeks after location secured.

MacKavanagh, James L., M.D., 160 Marion Avenue, Marrick, L. I., New York, age 44, married, Roman Catholic, graduate Georgetown University Medical School, 1934, presently in general practice, wishes to relocate, priority 3, interested in general practice in Georgia, size of community not too important, available within two or three months after location is selected.

Taber, Richard P., M.D., Department of Pediatrics, University Hospital, Ann Arbor, Michigan, age 30, single, Presbyterian, graduate University of Rochester Medical School, 1948, residency Buffalo Children's Hospital, N. Y.; University Hospital, Michigan, priority 4, interested in pediatrics in Georgia, available July 1, 1954.

Allen, Raymond A., M.D., c/o Mayo Foundation, Rochester, Minn. Born November 6, 1921, Lyman, Utah, single, Mormon, graduate University of Louisville, 1946, assistant resident in pathology one year, New York City Hospital, Fellow in pathology three years, Mayo Foundation, interested in location in Georgia, available July, 1955.

Battle, William C., 1st Lt., USAF (MC), 6407th USAF Hospital, Fearncom Air Base, APO 323, c/o Postmaster, San Francisco, Calif. Graduate Duke Medical School, 1949, surgical internship at Duke 1949-50, Pediatric internship at Long Island College Hospital, 1951-52, Board eligible in pediatrics, plan to take exams this year, currently completing a tour as pediatrician at the 6407th USAF Hospital, Tachikawa, Japan. Available July, 1954.

Bragg, Rudolph, M.D., 567th Medical Squadron, McChord Air Force Base, Washington, age 28, single, Methodist, graduate Medical College of Georgia, 1952.

license held in Georgia, interested in general practice as an individual or associate, in community under 10,000 in Georgia. Available July 1, 1954.

Ganl, Jack H., M.D., Lafayette Charity Hospital, Lafayette, La., age 31, single, Episcopalian, graduate Louisiana State University Medical School, 1952, rotating residency, Lafayette Charity Hospital, interested in general practice, in clinic or as an associate, available July 15, 1954.

Gray, Henry T., M.D., 9-C Copeley Hill, Charlottesville, Va.; will complete residency in dermatology and syphilology in June of this year, will be Board eligible, most interested in an association with another dermatologist or a group, would not be opposed to solo practice.

Kinzer, Gilbert M., Lt. MC USN, Main Dispensary, USNAS, Corpus Christi, Tex., 30 years of age, B.A. degree Vanderbilt University, M.D. degree University of Tennessee, 1947, have a basic science certificate and medical license, owned and operated a small hospital in Caraway, Ark. (GP-Surgery) took PG course in pediatrics at Harvard Postgraduate Medical School, called to active duty '51, graduated from School of Aviation Medicine, which gives special training in EENT, cardiology and physiology, desires to locate in South in a town with minimum 3,000 population, town must have hospital, plans to do general practice with obstetrics and limited major surgery, prefers an association with another doctor.

Moore, Melvin, M.D., 915 East 17th Street, Brooklyn, N. Y. Born January 5, 1924, married, Hebrew, graduate Chicago Medical School, 1946, certified by American Board of Radiology, residency, Newark Beth Israel Hospital, Queens General Hospital, specialty, Radiology, available March, 1954. York 29, N. Y., age 33, married, Protestant, graduate New York Medical College, 1954, draft exempt by previous service, interested in general practice in Georgia, available July, 1955.

Moseley, Robert W., M.D., 97th General Hospital, APO 757, c/o Postmaster, New York, N. Y., age 28, married, Christian, graduate Medical College of Virginia, 1948, residency Walter Reed Army Hospital, Board eligible for pediatrics. Available July 1, 1954.

Pattison, John D., M.D., FASRON 104 Det. 1, FPO, New York, N. Y., age 34, married, Protestant, graduate University of Pittsburgh, 1944, residency VA Hospital, service completed October 5, 1954, specialty internal medicine, clinic or group practice in Georgia, available one or two months after discharge.

Rutledge, James W., M.D., The John Gaston Hospital, Memphis, Tenn., age 29, married, Protestant, graduate New York Medical College, FFAH 1953, priority 4, served 30 months in USAAF, completing rotating internship at University of Tennessee, interested in general practice in Georgia, available July, 1954.

Schiffett, Joseph Ray, M.D., US Naval Hospital, Jacksonville, Fla., age 29, married, one child, Protestant, graduate Baylor University College of Medicine, 1953, priority 4, interested in general practice in Georgia, available August 1, 1954.

Shea, Wm. H. H., M.D., 568th USAF Dispensary, McGuire Air Force Base, Trenton, N. J., age 33, married, Roman Catholic, graduate University of Maryland, 1951, priority 4, interested in general practice, available July 15, 1954.

Stark, C. V., M.D., Box 109, Arcadia, Fla., wants practice in Georgia during spring of the year only, as he spends winters in Florida, born November 25, 1878, widower, graduate Oploma Medical University, Tenn., 1900, specialty—general medicine, population 1,000 or more.

Bonner, Mack S., M.D., 133 Jackson Drive, Slocum Village, Havelock, N. C. Will be discharged from the Navy within next six to eight months; graduate Medical College of Georgia; licensed in Georgia; interested in general practice in which also might practice some anesthesia.

Brannon, R. A., Jr., M.D., Vicksburg Clinic, 1600 Monroe Street, Vicksburg, Miss. Interested in establishing practice in Dermatology and Allergy at Brunswick, Georgia. Board eligible in Dermatology; had seven years experience as a health officer.

Ewing, George B., M.D., LaFargeville, New York, 50 years of age; married; Methodist; graduate Vanderbilt Medical School, 1929. Presently in practice, desires change of climate; Priority 4; interested in general practice in community of 1500 to 2000 in Georgia. Available early fall.

McCorkle, Robert G., Jr., M.D., 350 South Fuller 4J, Los Angeles, Calif. Age 30; married; Catholic; graduate Baylor University School of Medicine, 1946; priority 4; specialty—Thoracic Surgery. Interested in association with another doctor. Available August 1, 1954.

Moseley, Charles H., M.D., 707 Duncan Avenue, Killeen, Texas. Graduate Medical College of Georgia, 1952. Desires to become associated with a competent general surgeon to assist in surgery and do general practice. Available July 1, 1954.

Psimas, James M., M.D., M.O.Q. H-2, Cherry Point, North Carolina. Age 30, married, two children, Episcopal, graduate University of Virginia, 1948. Residency N. C. Baptist Hospital; St. Luke's Hospital, and DePaul Hospital, Specialty—Ob-Gyn only. Group preferred. Available September, 1954.

Schneider, Chas. F., M.D., VA Center, Biloxi, Mississippi. Age 36. Married, Lutheran, graduate University of Virginia School of Medicine, 1943; certified by the American Board of Surgery; presently in practice, desires private type practice; priority 4. Specialty—general surgery. Available 60 to 90 days notice.

NOTE: The Medical Association of Georgia assumes no responsibility for information herewith printed—it is for information only. Anyone interested is advised to make such investigations for verification as he deems necessary.

Hendrick, James Wesley, M.D., 7030 Cohn Street, New Orleans, Louisiana. Age 30, married. Methodist, graduate University of Tulane Medical School, 1949. Will be board eligible Ob-Gyn in July, 1954. Specialty—Ob-Gyn; prefers assistant or associate. Available July 1, 1954.

Ingram, William, Jr., M.D., U.S. Naval Hospital, Oakland, Calif. Age 32. Married. Protestant. Graduate University of Georgia School of Medicine, 1946. Residency USNH, Philadelphia; St. Albans, N. Y.; Oakland, California. Specialty—Neuropsychiatry (Clinic or institutional). Available June, 1954.

Moore, George W. St. Clair, M.D., 101 Ardmoor Avenue, Danville, Pa. Age 29. Married. Protestant. Graduate of University of Pennsylvania, 1948. Residency Geisinger Memorial Hospital and Foss Clinic. Specialty—Urology. (Clinic, Assistant or Associate). Available July, 1955.

Shanahan, John Rush, M.D., 10310 Greenfield Street, Kensington, Maryland. Age 39. Married; Roman Catholic. Graduate Georgetown University, 1948. Residency U. S. Naval Hospital, Bethesda, Maryland. Priority 5. Specialty—Internal Medicine. Desires community in Georgia of 20,000 to 30,000. Available June, 1955.

Newman, Harvey, M.D., US Naval Hospital, Beaufort, S. C. Age 28; married; Protestant; graduate Medical College of Georgia, 1948. Residency Children's Medical Center, Dallas, Texas. Specialty—pediatrics. Interested in community in Georgia as associate or assistant. Available August 1954.

Reichel, Hans A., M.D., 302 East Huntingdon Street, Savannah, Georgia. Interested in relocating in Georgia as an internist or in general practice or industrial medicine.

Woods, E. Ashby, M.D., Montevideo, Penn Laird, Virginia; graduate University of Virginia, 1952; age 30; married, interested in obtaining a position as either an assistant or in industrial practice in Georgia.

Dodd, Patricia, M. D., (See Robert S. McDuffie) Married, one child; 33 years of age; native of Savannah; graduate University of Maryland Medical School; taken part I of the American Board of Surgery; wants location where husband and wife can practice.

Kemp, Gordon Blair, M. D., 809 S. Marshfield Avenue, Apt. 108, Chicago 12, Illinois; born October 30, 1924; married; Protestant; graduate Hahnemann Medical College, Pennsylvania, 1949; residency - Illinois Eye and Ear Infirmary; Priority 4; specialty - Ophthalmology; available July 1, 1955.

McCorvey, Norborn B., M. D., 543 Garfield Street San Francisco, California; age 34; married; Presbyterian; graduate Tulane University School of Medicine, 1944 residency, Jefferson-Hillman Hospital; 3½ years residency in Urology; Priority 4; available immediately.

McCoy, John M., (Capt. 059752), 121st Evacuation Hospital, APO 971, c/o Postmaster, San Francisco, California; age 31 married, 2 children; Presbyterian; graduate Duke University, 1947; residency - George Washington University Hospital, VA Hospital; eligible to take Part II, American Board of Internal Medicine; available March 1, 1955.

McDuffie, Robert S., M. D., US Naval Hospital, Quarters No. 1219, Quantico, Virginia; married, one child; 35 years of age; native of Atlanta; graduate Emory University School of Medicine; specialty - Ob-Gyn; want location where husband and wife can practice.

Mackoff, Sam M., M. D., 612 W. Center Street, Lebanon, Illinois; age 39; married Synagogue; graduate University of Minnesota, 1943; Board eligible Dermatology; interested in establishing practice in clinic; available February 20, 1955.

Rozzell, Leo H., M. D., 14 Valley Street, Lewistown, Pennsylvania; age 45; married; Presbyterian; graduate University of Western Ontario, 1939; residency - St. Luke's Hospital; Priority 4F; specialty - Ophthalmology; Available August 1954.

Upchurch, Kent P., 215 Pine Valley Road, Winston-Salem, N. C.; age 30; married; Protestant; graduate Bowman Gray School of Medicine, 1946; Board qualified in Ob and Gyn; interested in group practice or woman's clinic as an assistant or associate; available September 1, 1954.

Suelling, John M., Jr., M. D., 1506 Waverly Avenue; Charlotte, N. C. Born in Augusta, Georgia; graduated from Medical College of Georgia, 1943; in June 1953 completed a four year residency in general surgery at Youngstown Hospital, Ohio; prefer solo practice, but would consider an association; Board eligible; if necessary could do some general practice to get started; now available.

Sullivan, Francis Simon, 4368 Carnegie Street, Wayne, Michigan; age 29; married Presbyterian; graduate University of Virginia, 1949; residency - Wayne County General Hospital; 3 years residency in internal medicine; priority 4F; specialty internal medicine; available October 1954.

AVAILABLE LOCATIONS

Meigs, Georgia - Thomas County - one doctor's clinic available, with ample space for a two doctor set-up; one aged doctor; hospital facilities nearby; good schools; paved highways; contact: Mr. O. H. Lewis, Meigs Clinic, Inc., Meigs, Georgia.

Pearson, Georgia - Atkinson County - will furnish house and equip clinic; new Hill-Burton Hospital at Douglas guarantees staff privileges to GP; office will be rent free for six months; contact Mr. Barney Kraft, Pearson, Georgia.

Dawsonville, Georgia—(Dawson County) Have a modern well equipped health

clinic. Arrangements for an office can be made without difficulty. No physician in county. (pop. 500) Contact: Mr. Carlton Gilleland, Mayor City of Dawsonville, Dawsonville, Georgia.

Doraville, Georgia (DeKalb County). Hospital in nearby Chamblee, small clinic in Doraville for rent. New homes being built \$8,950.00 up. Grammar-high school. Social and recreational facilities. Population sufficiently large enough to support physicians. (County pop. 30,900). Contact: Mr. George W. Walker, City Clerk, Doraville, Georgia.

Villa Rica, Georgia (Carroll County) New 24 bed HB hospital to be built soon. Now have seven bed hospital. Office available for lease, reasonable. Housing available at reasonable cost. 12 grade accredited school. (Pop. 3,200). Contact: Mr. Edgar P. Candler, Villa Rica, Georgia.

Buchanan, Georgia—(Haralson County) No physicians in area; 20 bed hospital, not in use, may be purchased at give away price. Housing available rent or buy reasonably. Need two doctors to run hospital or clinic, as they so desire. Contact: Mr. P. G. Camp, Buchanan, Ga.

Cumming, Georgia—(Forsyth County). Located 40 miles north of Atlanta on U.S. Highway 19. Office and clinic building now vacant that can be fixed immediately to suit one or two doctors, either with clinic, hospital or office set-up. As president of the bank in Cumming, in position to help young doctor get started. Good churches, schools, city clubs and living conditions. Population 2,500, county 15,000. Contact: Mr. Roy P. Otwell, Cumming, Georgia.

Blackshear, Georgia — Pierce County — Opening for two physicians, new air conditioned completely modern clinic, fully equipped and located directly across street from new 25-bed Hill Burton Hospital. Established practice which will gross \$40,000 per year. No significant competition from other doctors. Housing available. Assume one year lease on clinic and notes on equipment, if desired other arrangements can be made. Contact: Dr. T. C. Nation, Box 68, Blackshear, Georgia.

Marietta, Georgia—Cobb County—Interested in Negro physician to replace present physician who is going into armed forces. Contact Mr. Millard L. Wear, Administrator; City of Marietta Hospital Authority; Kennestone Hospital, Marietta, Georgia.

Roberta, Georgia—Crawford County — No physician in area, county maintains a large home with most reasonable rental available for resident doctor. Plans for clinic nearing completion, immediate use of rooms in present clinic building, also three rooms over post office ready for use, year's rent free. Excellent opportunity for qualified physician looking for general practice. Contact Mr. J. Welborn Johnson, P. O. Box 143, Roberta, Georgia.

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Emory University Hospital

Ponce de Leon Infirmary

Constitution and By-Laws Committee Meeting

Augusta, July 11, 1954

PRESENT AT THE meeting of the Committee on Constitution and By-laws on Sunday, July 11, 8 a.m., at the Hotel Bon Air were the following members:

J. W. Chambers, Chairman, presiding; Thomas W. Goodwin; David Henry Poer; William Harbin; H. Dawson Allen. Also present were H. L. Cheves and Messrs. Milton D. Krueger and John F. Kiser.

The Committee voted to study the entire Constitution and By-Laws of the MAG during the coming year. Each member of the Committee was assigned a section of the Constitution and By-laws to study. Each member will submit sug-

gested revisions at the next meeting of the committee to be held on October 10th in Atlanta.

Committee members pointed out a number of instances where revision of the Constitution and By-laws is necessary due to loose wording or inaccurate phrasing.

It was agreed that each member would submit their suggested revisions in writing to the headquarters office before September 1st. The copies of these revisions would be sent out from the headquarters office to each member of the committee.

Meeting adjourned.

Executive Committee of Council Meeting

Augusta, July 11, 1954

FIRST MEETING OF THE 1954-'55 MAG Executive Committee of Council was called to order at 2 p.m., Sunday, July 11th, at the Bon Air Hotel, Augusta, by President Peter B. Wright.

Members present, in addition to Dr. Wright, were David Henry Poer, Atlanta; H. L. Cheves, Union Point; J. W. Chambers, LaGrange; H. Dawson Allen, Milledgeville, and William Harbin, Rome. Also present was Mr. John F. Kiser.

The following action was taken:

1. Approved the formation of a Committee of Council to consist of three members of the MAG to meet with three representatives of the State Health Department and three representatives of the Board of Regents. The duties of this committee will be to act for Council and receive information concerning the new policies to be followed in the operation of the Medical College of Georgia and Talmadge Memorial Hospital. Appointed to the committee from the MAG were: Julian K. Quattlebaum, Enoch Callaway and

Peter B. Wright; from the State Health Department, Lee Rogers, J. Miller Byne, Jr. and Thomas W. Goodwin; and from the Board of Regents, Carey Williams, Edgar R. Pund and Mr. Roy Harris. This action followed a morning session with representatives of the State Health Department and Board of Regents.

In addition to members of Executive Committee, also present at the morning session were Mr. Harmon W. Caldwell and Mr. Roy Harris of the Board of Regents; Lee Rogers, T. F. Sellers, Rufus Payne and Mr. E. B. Davis, State Board of Health.

2. Recommended that a Code of Ethics be sent to every member of the Association and every new member, and that a copy of the MAG Constitution and By-Laws be sent to every new member.

3. Referred the matter of allotment of \$1,000 to the Crawford W. Long Memorial to the Committee on Auditing and Appropriations for action.

4. Referred to the Constitution and By-Laws Committee the request of the Maternal and Infant Welfare Committee for staggered terms of office for members.

5. Referred to Secretary Poer a recommendation by the Honorary Advisory Board that the MAG membership and bookkeeping records be streamlined.

6. Approved payment of half MAG dues by new members after July 1st, provided that the county society also accepts half dues.

7. Approved that all members who are delinquent in payment of dues should receive a letter giving them ten days to pay their dues. At the end of that ten days those members not remitting dues will no longer receive the *Journal* or be eligible for medical defense or have the right to vote or hold office.

8. Recommended that the Professional Conduct Committee consider a professional conduct problem in Polk County, and, pending a decision by the Wayne County Medical Society, the com-

mittee was asked to look into a problem in that county. It was voted to inform members of the Hospital Committee about these two professional conduct problems.

9. Recommended that the MAG headquarters office staff accept invitations to all future meetings of the State Board of Medical Examiners and State Medical Education Board.

10. Approved the appointment of William Harbin to the Executive Committee as an advisor.

11. Approved a life insurance plan for members of the Association proposed by Mr. Lafayette Davis of the Provident Life and Accident Insurance Company.

12. Approved and endorsed the work of the Insurance Board at their meeting in Augusta on the same day. The Board reported to Council concerning its work in revising the Georgia Plan and all actions taken by the Insurance Board were heartily endorsed by members of the Executive Committee of Council.

Meeting adjourned.

Blindness in Young Children

In the past ten years there has been a 20 per cent increase in blindness among preschool children, according to a report in the *American Journal of Public Health* of October, 1953.

The number of children born blind appears to be increasing and the cause is attributed to retrolental fibroplasia, a condition marked by the formation of fibrous tissue behind the lens of the eye. This seems especially to affect premature babies.

The seriousness of this condition may be seen from the fact that approximately 50 per cent of all infants weighing three pounds or less at birth show some evidence of the acute phase of this eye disorder, and it is at present the greatest cause of blindness among children under five years of age. The condition was first described in 1942 and has spread considerably during the past ten years.

Recent figures indicate that among children below seven years of age, one in 4,000 is blind. Although progress has been made in preventing blindness from infectious agents and from injuries, the growing prevalence of retrolental fibroplasia among premature babies has produced a net increase in blindness. While research goes forward

to find the cause of retrolental fibroplasia, the problem of caring for an increasing number of blind children mounts.

It is further estimated that one child in 500 has corrected visual acuity in the better eye of 20/70 or worse, or has other conditions seriously affecting useful vision but short of blindness. On the basis of national estimates, there are about 1,400 partially-seeing children in the schools of Georgia. Few of them receive all the benefit of special facilities needed to equalize their educational opportunity.

Many children with less serious eye problems are not receiving periodic screening tests and lack the corrective services needed to enable them to see properly.

The five common eye defects that glasses can help correct are myopia (near-sightedness), astigmatism, hyperopia (far-sightedness), presbyopia (aging eyes) and strabismus (double vision, wall-eyes and cross-eyes).

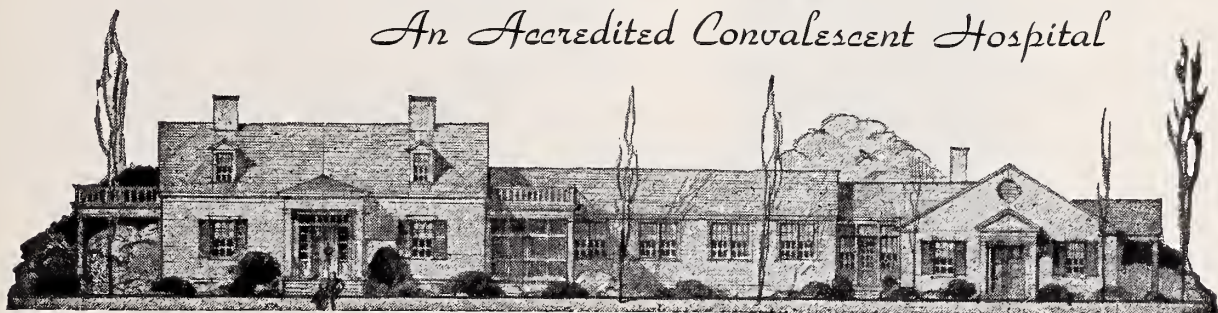
About one child in 150 has strabismus. This deviation of the eye muscle requires proper care before the age of four if useful vision in the deviating eye is to be developed. Many children enter school without correction of this condition.

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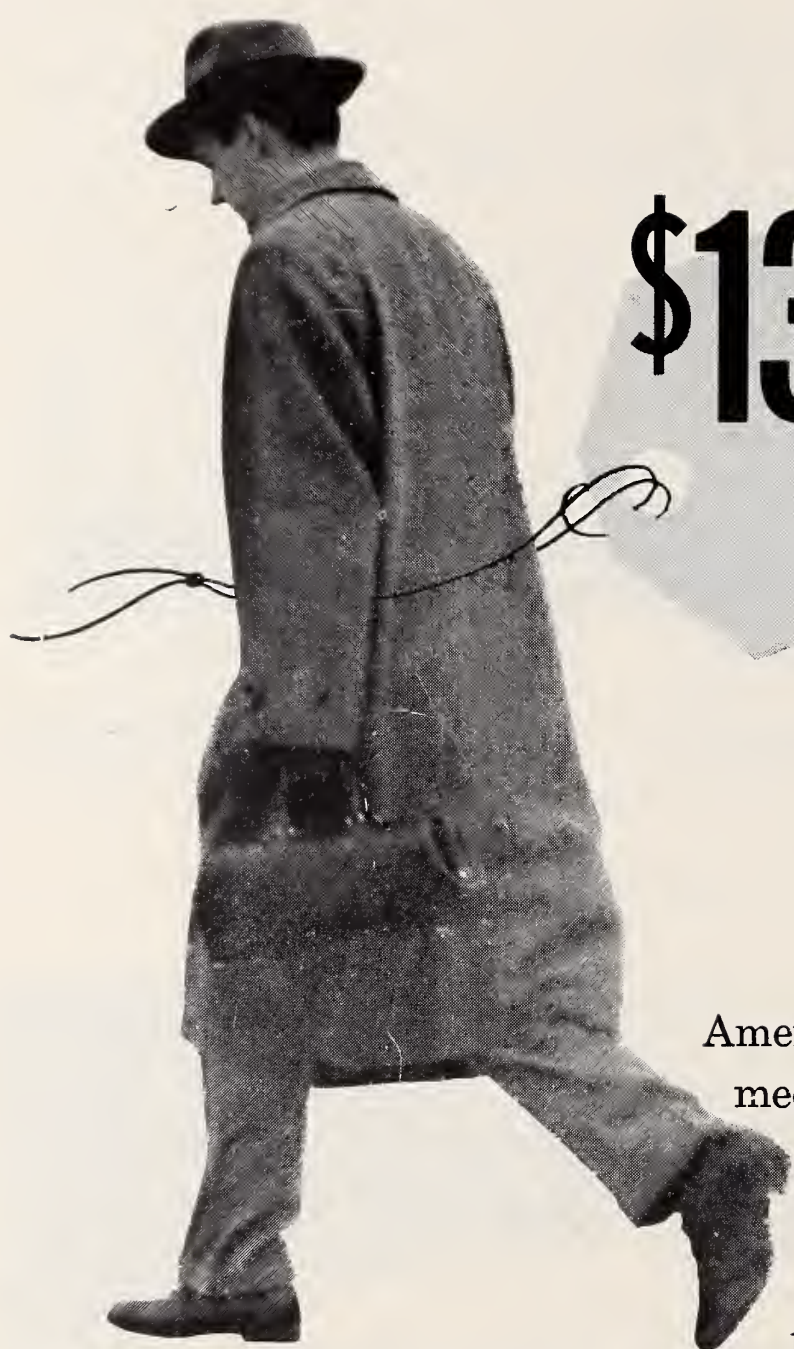
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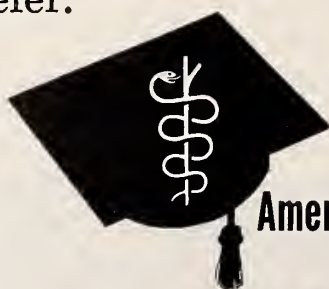
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American Medical Education Foundation

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Industry's Aid to Medical Education

Last year 994 corporations in this country contributed \$1,356,000 in support of the nation's 79 medical schools—an increase of 74 per cent dollar-wise, and 193 per cent in number of corporate givers over the previous year.

Matching this aid from industry were gifts totaling \$1,044,000 from the nation's physicians, both sums being channeled through the National Fund for Medical Education. Its goal is \$10,000,000 in annual support for the medical schools, three fourths of it to come from American business and industry.

Prime movers in the organization of this fund were President Eisenhower, who at the time, in 1949, was president of Columbia University, and ex-President Herbert Hoover, who is now honorary chairman of the fund.

This organization will perhaps prevent the national government from making further inroads

on the control of public health. Ernest T. Weir, chairman of National Steel, recently stated his reason for supporting the National Fund for Medical Education, as follows:

"A corporation has no real choice of whether or not it will support medical education. The actual choice is whether it will support medical education privately or through taxation. And when government support enters, government control follows."

Mr. Weir's reasoning holds equally well, of course, for government support of colleges and universities other than those engaged specifically in teaching medicine. In fact we may soon find that we in the South have paid dearly for the government's handouts that have financed housing projects. If the recent ruling of the Supreme Court is strictly enforced regarding schools which the national government has not built, the housing projects it has built are sure to come specifically under the non-segregation edict.

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ANNOUNCEMENTS

Contests

International Academy of Proctology—Annual Cash Prize and Certificate of Merit Award Contest for 1954-1955. The best unpublished contribution on Proctology or allied subjects will be awarded \$100.00 and a Certificate of Merit. This competition is open to *all* physicians in all countries. All entries are limited to 5,000 words, must be typewritten in English, and submitted in five copies. All entries must be received no later than the first of February 1955. Awards will be made in March 1955. Address entries to the International Academy of Proctology, 43-55 Kissena Boulevard, Flushing, New York.

Caleb Fiske Prize of the Rhode Island Medical Society—Medical Essay Competition. The subject for this year's dissertation is "Modern Developments in Anesthesia." Papers must be typewritten, double spaced, and should not exceed 10,000 words. Cash prize of \$250.00 is offered. For further information write the Secretary, Caleb Fiske Fund, Rhode Island Medical Society, 106 Francis Street, Providence 3, R. I.

Meetings

American Association of Blood Banks—Shoreham Hotel, Washington, D. C., September 13, 14, 15, 1954. For information write to the Office of the Secretary, American Association of Blood Banks, 3500 Gaston Avenue, Dallas, Texas.

National Society for Crippled Children and Adults—Hotel Statler, Boston, Mass., November 3-5, 1954. For further information write to 11 South LaSalle Street, Chicago 3, Ill.

Inter-Society Cytology Council—Boston, Mass., November 12 and 13, 1954. For information write to the Secretary-Treasurer, Inter-Society Cytology Council, 634 North Grand Boulevard, St. Louis, Mo.

American Heart Association's Council for High Blood Pressure Research—Cleveland, Ohio, October 22 and 23, 1954. For further information contact the Georgia Heart Association, Western Union Bldg., Atlanta, Ga.

American Congress on Obstetrics and Gynecology—Palmer House, Chicago, Ill., December 13-17, 1954. For information write to the Sixth American Congress on Obstetrics and Gynecology, 116 South Michigan Ave., Chicago 3, Ill.

American Occupational Therapy Association—Shoreham Hotel, Washington, D. C., October 16-22, 1954. For further information write to the American Occupational Therapy Association, 33 West 42nd Street, New York 36, N. Y.

Academy of Psychosomatic Medicine—Plaza Hotel, New York, N. Y., October 8-9, 1954. The program will be devoted to "Psychosomatic Aspects of Surgery." Those interested in presenting papers should write to Dr. Benjamin Raginsky, 376 Redfern Ave., Montreal, Canada, stating their special interest.

International College of Surgeons—Palmer House, Chicago, Ill., September 7-10, 1954. For information write to International College of Surgeons, 1516 Lake Shore Drive, Chicago 10, Ill.

Southern Medical Association—St. Louis, Mo., November 8-11, 1954. For further information write the Southern Medical Association, Empire Building, Birmingham 3, Ala.

Georgia Heart Association—General Oglethorpe Hotel, Savannah, Ga., September 24 and 25, 1954. Speakers include J. N. Morris, Medical Research Council of the United Kingdom, London, England; Willis J. Potts, Northwestern University, Chicago, Ill.; George E. Burch, Tulane University, New Orleans, La.; and Thomas Findley, Medical College of Georgia, Augusta. The Scientific Sessions are approved by the Georgia Academy of General Practice for post-graduate hours. For further information write to the Georgia Heart Ass'n., Inc., Western Union Bldg., Atlanta, Ga.

American Congress of Physical Medicine and Rehabilitation—Hotel Statler, Washington, D. C., September 6-11, 1954. For further information write to the American Congress of Physical Medicine and Rehabilitation, 30 North Michigan Ave., Chicago 2, Ill.

Joint meeting of the *Georgia Chapter of the American College of Surgeons*, the *Georgia Urological Association*, and *Georgia Society of Anesthesiologists*; King and Prince Hotel, St. Simons Island, Sept. 30-Oct. 1, 1954. For reservations write to the manager, King and Prince Hotel, St. Simons Island, Ga.

Courses

Newer Developments in Cardiovascular Diseases, Mount Sinai Hospital, New York, October

11-15, 1954. The course is given under the auspices of the American College of Physicians.

Ninth Annual Postgraduate Course on Diseases of the Chest, Hotel Knickerbocker, Chicago, Ill., October 18-22, 1954, and *Seventh Annual Post-*

graduate Course on Diseases of the Chest, Hotel New Yorker, New York City, November 8-12, 1954. For further information write to the Executive Director, American College of Chest Physicians, 112 East Chestnut Street, Chicago 11.

SOCIETIES

The CHEROKEE-PICKENS MEDICAL SOCIETY met recently at the Hotel Canton in Canton. Henry Dewitt Meaders, Marietta, addressed the group on "The Rh Factor as It Pertains to Pregnancy." Following discussion there was a movie on peptic ulcers.

The FULTON COUNTY MEDICAL SOCIETY met July 1, 1954, at the Academy of Medicine in Atlanta. The theme of the meeting was "Inhalation

Therapy—Its Use and Abuse." A. R. Gholson showed a movie on "The Physiology of Anoxia." A demonstration of equipment and a panel discussion, moderated by T. L. Tidmore, followed. Those participating were John O. House, M. Bedford Davis, Richard Blumberg, R. L. Stephenson, Donald S. Bickers, and Michael V. Murphy.

The LAURENS COUNTY MEDICAL SOCIETY met July 16, 1954, in Dublin. Speaker at the meeting was Walter Barnes, Macon, whose subject was "Low Back Pain." The next meeting will be held in September.

PERSONALS

C. F. ALLEN, JR. and Y. F. CARTER, JR., have announced the opening of offices in the Rose Building in Ashburn. Dr. Carter is from Ray City; he received his pre-medical education at Emory University, Atlanta, and was graduated from the Medical College of Georgia, Augusta. Dr. Allen is a native of Brunswick; he is also a graduate of Emory University and the Medical College of Georgia. Drs. Allen and Carter served their internships at Macon City Hospital in Macon.

SAMUEL S. AMBROSE, Atlanta, spoke on "Non-specific Urethritis" at the Twenty-second Annual Venereal Disease Conference sponsored by the U. S. Public Health Service and the University of California at Los Angeles.

RUPERT BRAMBLETT, Cumming, his wife, and their two children Patsy and Remelba are vacationing in Mexico and Central America, according to "The News" of the Ninth District.

PIERPONT F. BROWN, JR., Gainesville, announces the association of PIERCE K. DIXON, JR., for the practice of General Surgery at 646 East Spring Street.

R. A. BURNS, Blue Ridge, announces his return to practice after two years service in the U. S. Air Force. He entered the service in June of 1952 and, after taking the introductory course in Aviation Medicine in Montgomery, Ala., he was sent to Korea. Dr. Burns was stationed in Korea for a year; since that time he has been base surgeon and commander of the 2584th USAF Dispensary in Memphis, Tenn.

BRASWELL COLLINS, Macon, was recently honored as one of the two "Lions of the Year" by the Macon Lions Club. He received the award for his outstanding work in the Lions' sight-conservation program by providing free examinations for persons with eye defects.

ERNEST F. DANIEL, JR., Dawson, has closed his office and terminated the general practice of medicine to accept a residency in surgery at the University Hospital in Augusta.

FLOYD E. DAVIS, Waycross, announces the re-opening of his office at 201 Nichols St. for the practice of medicine.

WILLIAM B. FACKLER, JR., LaGrange, spoke to the LaGrange Kiwanis Club on "Obesity." He discussed causes of obesity, pointing to overeating as the most common culprit, and he discussed the

causes of overeating. Dr. Fackler summed it all up this way, "The cause of obesity boils down to the fact that we take in more than we burn up."

EDGAR BOLING, Atlanta, announces the association of HENRY FINCH for the practice of surgery of the colon and rectum. Their offices are in the Doctors Building.

REGINA GABLER, Atlanta, and IRVING L. GREENBERG, Atlanta, announce the removal of their offices to Suite 105 Medical-Dental Building, 950 West Peachtree St., N.E., for the practice of Gynecology and Obstetrics and the practice of Surgery, respectively.

F. OLAND GARRISON, Demorest, and Mrs. Garrison announce the birth of a son, Stanley Davis, at Athens General Hospital, June 19, 1954.

LAMAR F. GLASS, Atlanta, announces the opening of his office at 403 Boulevard, N.E., for the practice of General Surgery.

GEORGE F. GREEN, Sparta, has assumed complete ownership of the Tanner-Green Clinic, and he has announced that the clinic would henceforth be known as simply "Green Clinic." D. E. TANNER has retired from the firm to move to Augusta.

THOMAS GUCKER, Warm Springs, discussed various aspects of poliomyelitis and described advances made in controlling the disease at a recent luncheon meeting of the LaGrange Lions Club.

We reported in the July *Journal* that LAURIER E. HACKETT, Camilla, had been the victim of an attack of polio several weeks ago. Dr. Hackett is back at home now, recovering rapidly.

THOMAS M. HALL, Macon, announces the opening of his offices in Macon for private practice as a consultant psychiatrist. Dr. Hall received his M.D. degree from the Medical College of Georgia, Augusta. He served two years' residency at the University of Texas Medical College in the department of Neuro-Psychiatry and one year before that at the State Hospital in Newtown, Conn. Dr. Hall is a native of Milledgeville.

J. HAROLD HARRISON, Atlanta, announces the opening of his office at 478 Peachtree St., N.E., for the practice of general surgery.

DAVID E. HEIN, Atlanta, announces the opening of his office at 1083 West Peachtree St., N.E., for the practice of internal medicine and gastroenterology.

ARTHUR HENDRICKS, Perry, and Mrs. Hendricks spent their vacation this year in Nassau, The Bahamas. Their trip included a visit to Miami also.

WYCLIFFE W. HILLIS, Sardis, recently opened the Hillis Clinic in Sparta in association with his son, W. W. HILLIS, JR. The opening date, July 5, 1954, marks the 44th anniversary of the beginning of the practice of medicine in Sardis by Dr. Hillis, Sr. Dr. Hillis, Jr., is just beginning his practice having been graduate from the Medical College of Georgia in 1953; he served as intern for one year in Macon.

CHARLES D. HOLLIS, JR., and THOMAS D. JOHNSON, Albany, announce the opening of their offices at 305 North Jefferson Street with practice limited to internal medicine and cardiology.

JOHN M. HULSEY, Gainesville, left in his trailer, on June 26 for a two month vacation that will take him to Niagara Falls, into Canada and up to Alaska for some salmon fishing. Dr. Hulsey will return home via California and the southern route across the continent.

THOMAS K. LEWIS, JR., Atlanta, announces the opening of his offices at 27 Eighth St., N.E., for the practice of pediatrics.

LEONARD T. MAHOLICK, Columbus, spoke recently at the Kiwanis Club meeting on "You, the Community and Mental Health."

JAMES SIDNEY MAUGHON, Valdosta, has established his office for the practice of general surgery at 107 West Jane Street. Dr. Maughon is a native of Lumberton, N. C., and a graduate of the Medical College of Georgia. He served in the Navy during the recent Korean war and while at the naval hospital in Yokosuka, Japan, his group received the presidential unit citation for work done in the care of evacuated Marine forces.

L. ALLEN McDONOUGH, Atlanta, announces the opening of his office at 2387 Peachtree Road, N.W., for the practice of pediatrics.

WILLIAM W. MOORE, Atlanta, announces the removal of his offices from 133 Doctors Building to 146 Doctors Building, for the practice of neurological surgery, pending completion of new offices in the Strickler Building.

HAMIL MURRAY, Gainesville, recently joined the staff of the Hall County Hospital as director of laboratory service. Dr. Murray is a graduate of Emory University School of Medicine; he was

formerly resident at Grady Memorial Hospital, Emory University Hospital and the Veterans Administration Hospital in Atlanta, where he was chief of lab service and assistant professor of pathology at Emory University.

JACK C. NORRIS, Atlanta, has announced his candidacy for the office of Fulton County Commissioner. Dr. Norris stated, "Careful consideration has led me to the conclusion that in the future, doctors cannot stand aside and continue to leave their duties as citizens to others."

GEORGE T. NICHOLSON, Cornelia, wrote recently that Mrs. Nicholson had undergone surgery at the Habersham County General Hospital in June. We wish Mrs. Nicholson a speedy recovery.

HART ODUM, of Newnan and Columbus, has recently moved to Greenville to practice medicine in association with R. B. GILBERT at the Meriwether Clinic.

ROY W. RAY, JR., recently entered into the practice of general medicine and surgery with B. E. DANIEL in Alma. Dr. Ray is a graduate of the Medical College of Georgia where he also took additional training in surgery, urology and pathology. Dr. Ray served his internship in Macon in pediatrics and obstetrics and gynecology.

CHARLES K. RICHARDS, Calhoun, was made regimental surgeon of the 122nd Infantry regiment and promoted to the rank of major during the National Guard encampment at Ft. McClellan, Alabama.

HUGH K. SEALY, formerly of Emory University, announces the opening of his office at 765 Spring Street, Macon, Ga.

HENRY H. TIFT, Macon, and Mrs. Tift had a few days vacation in Hawaii after the AMA meet-

ing in San Francisco; also on this trip were Dr. and Mrs. EUSTACE ALLEN, Atlanta.

CHARLES E. TODD, Atlanta, announces the opening of his office at Suite 1, Howell House, 710 Peachtree St., N.E., for the practice of general surgery.

LOUIS F. TOLBERT, Powder Springs, has closed his office to accept a Fellowship in Internal Medicine at the Ochsner Clinic, New Orleans, La.

CURTIS F. VEAL, Milledgeville, announces the opening of his office at 380 Doles Avenue on July 1, 1954. Dr. Veal is a graduate of Emory University and the Medical College of Georgia. He served his internship at Macon City Hospital.

S. P. WISE, III, Americus, announces the opening of his office in the Wise Clinic Building, 142 S. Jackson Street. His practice will be limited to internal medicine and pediatrics.

FRANK F. WOOD, Albany, has been elected City physician, succeeding GLENN SEYMOUR who has resigned to continue his studies.

GRATTAN C. WOODSON, JR., Atlanta, announces the opening of his office at 248 Pharr Road, N.E., for the practice of internal medicine.

HAL HENSCHEN, Atlanta, announces the opening of his office for the practice of general surgery at 384 Peachtree St., N.E.

EDWARD D. REISMAN, Atlanta, announces the removal of his offices to 950 West Peachtree Street, N.E., for the practice of surgery.

A. J. WALTER, Sautee, and Mrs. Walter recently entertained the Habersham and Stephens County Medical Societies at bar-b-que chicken supper at their home in the Nacoochee Valley. A tremendous success from all reports.

DEATHS

LESTER NEVILLE, Dillard, 70, died July 2, 1954, of a heart attack while in his office attending a patient. Dr. Neville graduated in 1911 from the Southern Medical College in Atlanta, and he began his practice in Dillard shortly afterward. He was married to Miss Carrie Cannon in 1916 and they had one daughter, now Mrs. Harry L. Brown of Mountain City.

Dr. Neville was a member of the Dillard Methodist Church, of which he had served as a steward and a trustee; he was a member of the Board of Trustees of the Rabun Gap-Nacoochee School and a member of the Rabun County Board of Trustees.

The funeral was held July 3rd at the Dillard Methodist Church, and interment was in the Rabun Gap Methodist Church Cemetery.

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1. Werner, A.: Acta endocrinol. 13:87, 1953.

2. Malleon, J.: Lancet 2:158 (July 25) 1953.

3. Goldzieher, M. A., and Goldzieher, J. W.: Endocrine Treatment in General Practice, New York, Springer Publishing Company, Inc., 1953, p. 23.



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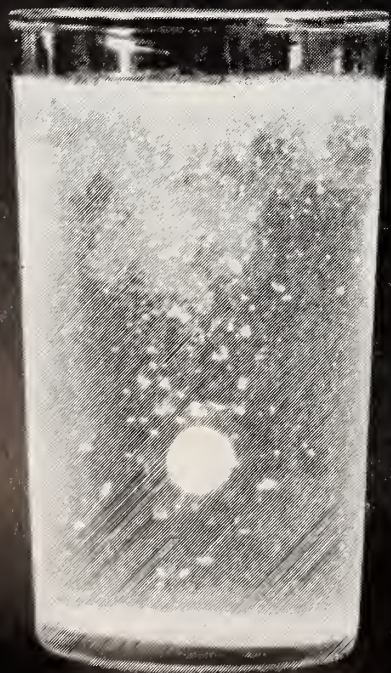
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Because of the swift absorption, your patient gets high blood levels of ERYTHROCIN (Erythromycin Stearate, Abbott) in *less than 2 hours*—instead of 4-6 hours as before. Peak concentration is reached within 4 hours, with significant concentrations lasting for 8 hours.

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MANUSCRIPTS

Articles are accepted for publication on the condition that they are contributed solely to this **Journal**. Manuscripts should be typewritten, double-spaced and the **original and two copies should be submitted**. Receipt of manuscripts will be acknowledged and unused manuscripts returned. Used manuscripts will be returned only if requested.

STYLE

Ordinarily articles should not exceed 3,000 words. Only under exceptional circumstances will articles of over 4,000 words be published. Footnotes, bibliographies and legends should be typed on separate sheets, double-spaced. Bibliographies should conform to the style of the Quarterly Cumulative Index published by the American Medical Association—i.e., name of author, title of article, name of periodicals with volume, page, month, day of month if weekly and the year. They should be listed in alphabetical order and numbered in sequence. Example: 1. Jones, S. R.: Spontaneous Epistaxis, Arch. Int. Med., 36:434 (Dec.) 1946.

NEWS NOTES

District and County Medical Societies, Association members and readers are invited to send in any news items of general concern to members of the Medical Association of Georgia.

REPRINTS

Requests for reprints should be made direct to Mr. T. D. Thompson, Franklin Printing & Mfg. Co., 675 Drewry Street, N.E., Atlanta, Georgia. Reprints must be ordered within 30 days after publication, since all type will be destroyed after that time.

ILLUSTRATIONS

Illustrations, tables, etc., should bear the author's name and figure number. Used photographs, drawings and cuts will be returned after publication only if requested. The cost of reproduction of illustrated material for publication will be borne by the author and the engraver will bill the author for this expense.

GENERAL POLICY

The Editor and members of The **Journal** Editorial Board will permit authors to have as wide a latitude as the general policy of the **Journal** and the demands on its space permit. The right to reduce, revise, or reject any material submitted for publication is always reserved. The **Journal** is not responsible for statements made by any contributor. All communications regarding editorial, advertising, subscription and miscellaneous matters should be sent The Editor, 875 West Peachtree Street, N.E., Atlanta, Ga.

ADVERTISING

All pharmaceutical advertising must be approved by the State Journal Advertising Bureau of the American Medical Association to be acceptable for publication. Other advertising copy may be accepted subject to the approval of the Editor and members of the Editorial Board. All copy or plates must reach the **Journal** office by 10th of the month preceding publication. General and classified advertising rates will be furnished on request.

MEDICAL EDITING SERVICE

If in the opinion of the **Journal** Editorial Board, material submitted for publication could be improved by a Medical Editing Service, the Editor will contact the author for his approval. Association members needing assistance in preparation of material for publication may also use this service. A reasonable charge is made for this service and the cost of this will be borne by the author.

Current reports^{1,2} describe the increasing incidence of resistance among many pathogenic strains of microorganisms to some of the antibiotics commonly in use. Because this phenomenon is often less marked following administration of CHLOROMYCETIN (chloramphenicol, Parke-Davis), this notably effective, broad spectrum antibiotic is frequently effective where other antibiotics fail.

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References

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The JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA, established 1911. Owned, edited and Copyright, 1954 by the Medical Association of Georgia, 875 West Peachtree Street, N.E., Atlanta, Georgia. Published monthly under the direction of the Council of the Association. Subscription rates: \$5 per year; \$1 per single copy. Entered as second-class mail at the post office at Atlanta, Georgia, under the Act of March 3, 1879. Accepted for mailing for the general rate of postage provided for in Section 1103, Act of October 6, 1917, authorized November 14, 1928.

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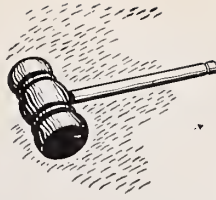
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president's page

Emory University School of Medicine will have its Centennial Celebration October fourth and fifth, nineteen hundred fifty four.

Throughout these one hundred years Emory has been supplying capable physicians, most of whom the State of Georgia has been fortunate enough to keep, whose services have relieved the suffering, improved the health, both mental and physical, and uplifted the standards of living of the citizens of Georgia or any other location in which they have settled.

Emory's part in the progress of Scientific Medicine has been outstanding and its potentials are unlimited. The alumni of Emory have set precedents which will forever be stimulating influences to those who follow.

In nineteen hundred seventeen U. S. Army Hospital No. 43, "The Emory Unit", was organized and sent to France to serve in World War I. Again in nineteen hundred forty-two "The Unit" served in North Africa and France during World War II.

While not until nineteen hundred fifteen did the school attain the name Emory University School of Medicine, it has existed since eighteen hundred fifty-four. First as the Atlanta Medical College which in eighteen hundred ninety-eight consolidated with the Southern Medical College forming the Atlanta College of Physicians and Surgeons. In nineteen hundred thirteen the Atlanta College of Physicians and Surgeons and the Atlanta School of Medicine merged and in nineteen hundred fifteen this combination officially became the Emory University School of Medicine.

While it is not possible to name the great men who received their medical education at Emory, it is fitting to pay special tribute to the leadership of Dr. J. G. Westmoreland in the founding of this most worthy institution.

We, of the Medical Association of Georgia and citizens of this great state, salute Emory and wish to express our sincere gratitude for its contributions to Medicine and its favorable influence on the profession and the public. May its upward trend ever continue.



Diuretic Therapy

PROPER USE OF the diuretic agents is invaluable in the control of edema due to most types of heart failure. Their use, however, is best reserved until adequate digitalis has been administered, since excess fluid is frequently excreted following the use of this drug alone, and the ensuing improvement masks the need for digitalis, the more specific therapy. The adoption of a suitable low-sodium dietary regime will reduce or preclude the need for diuretic therapy in many other patients.

The organic mercurials given parenterally are by far the most useful compounds available at this time. The choice of many commercial products depends upon the route of administration required for the particular patient being considered. Those containing theophylline, such as mersalyl (Salyrgan®) theophylline, and meralluride with theophylline (Mercuhydrin®) are much less irritating when used *intramuscularly*. Of these, meralluride with theophylline seems to be the most satisfactory, since it produces less pain. Some physicians combine these preparations with one-half to one cc. of procaine (one per cent) in order to diminish the local reaction. Mercaptomerin sodium (Thiomerin®) is the most suitable for subcutaneous use and is prescribed by many physicians for patients injecting themselves at home. The *intravenous* administration of theophylline-containing compounds may produce adverse effects; therefore, preparations which *do not include* this drug, such as mersalyl (Salyrgan®) and mercaptomerin sodium (Thiomerin®) and mercumatin (Cumertilin®) are much more satisfactory, but they also must be given cautiously.

All of these compounds may produce sensitivity reactions, renal damage and electrolyte imbalance; hence, it is expedient to begin with a test dose of one-half to one cc. *intramuscularly*, depending upon the severity of the failure and the renal status. Being certain that no renal disease is present may be difficult since moderate albuminuria, increased casts, red and white cells are found in the urine of patients with varying grades of failure. A more reliable guide is the urinary

concentration or the presence of gross uremia. Tolerance by the patient, indicated by diuresis, weight loss, and lack of adverse effects may be followed by therapeutic doses of two cc. or more, the former generally being sufficient. Small doses administered more often (i.e., one cc. three times weekly), when this amount suffices, are better than larger injections at more lengthy intervals (i.e., three cc. once weekly). Of course, in emergencies one may administer two cc. or more *intravenously*. Ordinarily, only an occasional injection is required, whereas the severely-ill may need two or three per week. It is well-recognized that ammonium chloride potentiates the effect of the mercurials. Its diuretic effect is through the production of acidosis, thereby promoting the loss of sodium in excretion of the acid products. Six to eight *grams* daily are required by the usual patient. These large amounts may be more conveniently given by using one gram tablets (Lilly, Brewer), or by using a 20 per cent solution orally, compounded in a suitable vehicle. Continuous therapy results in a loss of efficacy, so treatment with this drug should be interrupted at intervals of two to four days for four or five days. In resistant cases, mercurials should be injected towards the end of each period of ammonium chloride administration.

More recently, the introduction of mercumatin (Cumertilin®) in an oral form which rarely produces side effects has obviated the need for intensive parenteral therapy in many patients. The use of one to three tablets daily after meals for three or four days per week (observing the precautions previously outlined) may be beneficial. Chlormerodrin (Neohydrin®) is also used in the same manner, however, most patients cannot tolerate more than two tablets daily.

Acetazoleamide (Diamox®) is a non-mercurial diuretic which acts by inhibiting the action of carbonic anhydrase in the kidney. Since it can produce serious acidosis it should not be used in the presence of a kidney disease. Further study is necessary before this drug can be recommended for general use.



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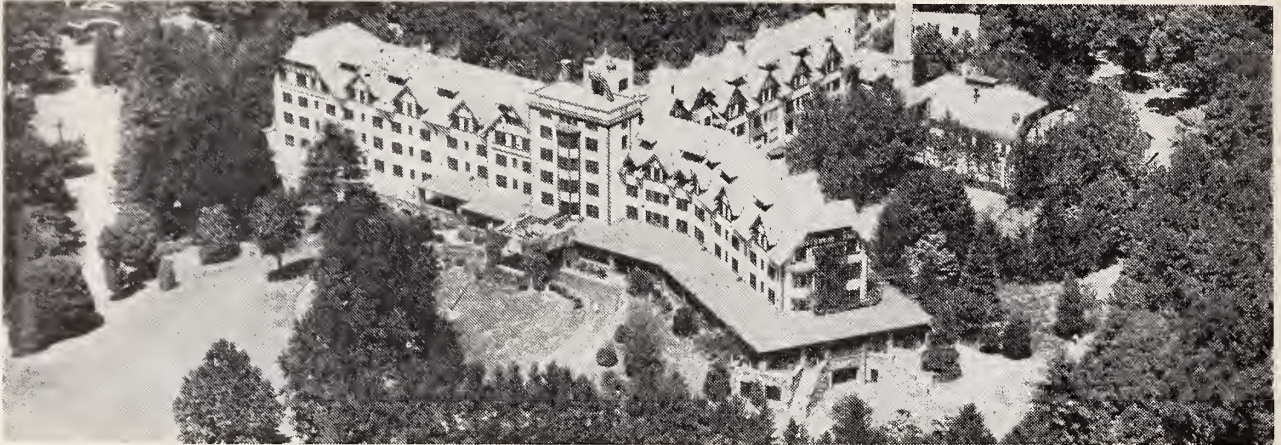
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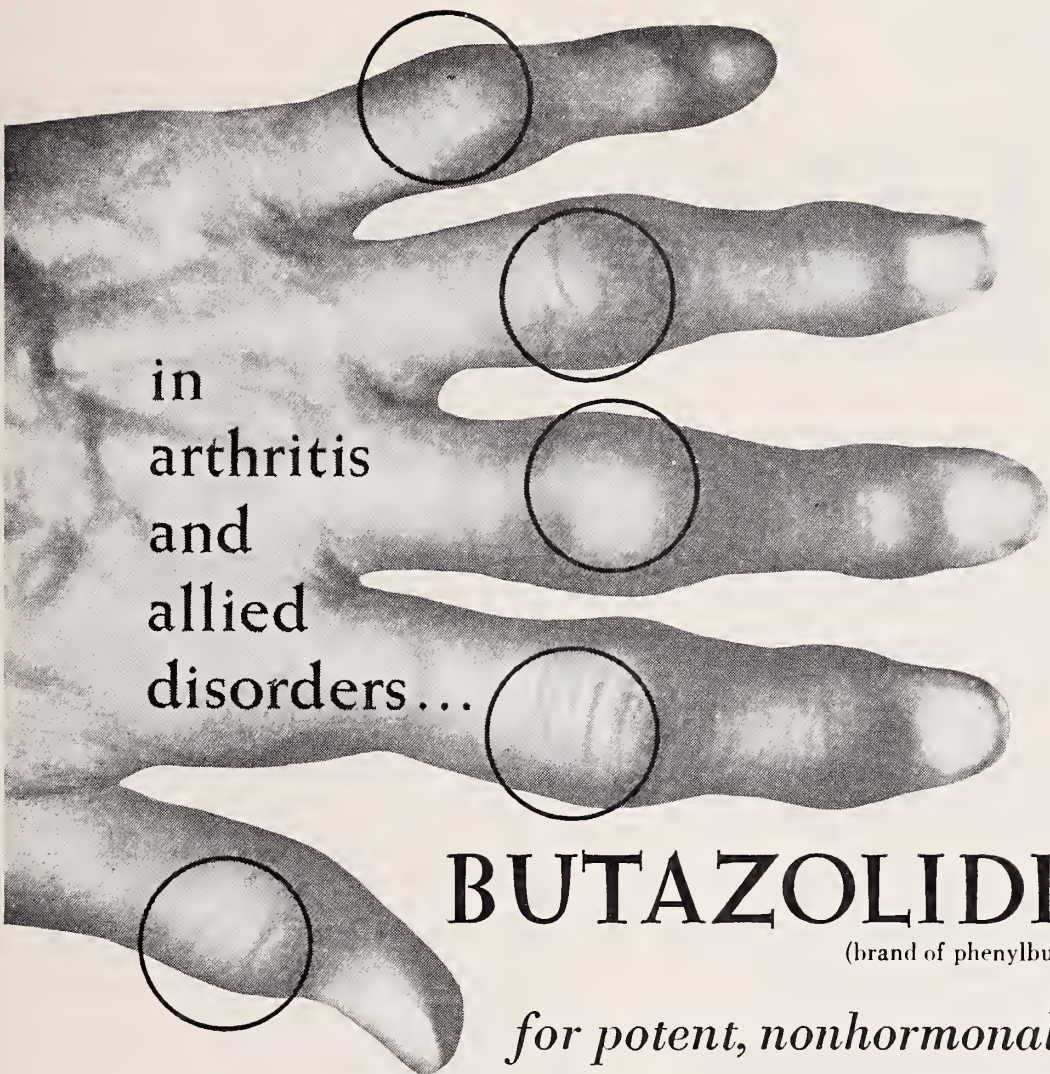
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Thyroid Carcinoma

A. H. LETTON, M.D., Atlanta, Ga.

THERE ARE MANY confusing and conflicting reports about cancer of the thyroid. Confusing and conflicting because the statistics we read do not seem in accord with our experiences. I recently compiled our personal statistics and was amazed to find that among all of the nodular goiters we have operated upon in the last five years, 10.1 per cent contained carcinoma; and of the solitary nodules removed in that same five years, 24 per cent were carcinoma. In 1948 we⁷ found that only five per cent of the nodular goiters of our patients were carcinomatous.

There are several reasons why there has been an increase in the percentage of carcinoma of the thyroid. First, the patients select themselves, i.e., it is the unusual patient who goes to the physician with a lump in the thyroid which has been present for some time and is not changing; second, it is unusual that the family physician refers a case to the thyroid surgeon unless he suspects that the nodule is either toxic or cancerous; and, third, there are certain goiters which the thyroid surgeon may elect not to operate on. Thus, we usually operate only on patients who have undergone a considerable degree of selection, with a weeding out of those who have lesions which are obviously not cancer. In these statistics to which we refer above, we are dealing only with the condition of patients who have been submitted to surgery, not with all people who have goiters. As our experience, that is, the experience of our referring physician, as well as of our thyroid surgeon, grows, the selectivity will become greater and greater causing a relative increase in the number of carcinomas among the goiters removed. Another factor causing a relative increase in the carcinomas found in the thyroid lies in the fact that there are fewer diffuse toxic goiters and fewer nodular goiters due, probably, to the more universal use of iodinated table salt as well as better mental and physical

health habits. Thus, there is a relative increase in the number of tumors (benign or malignant) of the thyroid over the number of nodular goiters caused by involution and hyperplasia of the gland. This was pointed out in a comprehensive review presented before the American Goiter Association in 1953 by Zimmerman.¹⁵

I averaged the incidences of carcinoma of the thyroid as reported recently by nine leading authorities (Lahey,⁹ Cope,⁵ Hinton,⁸ Cole,¹⁰ Crile,⁶ Beahrs,¹ Young,¹⁴ Cerise and Ochsner⁴ and Ward.¹³ Their reports of non-toxic nodular goiter in which they found carcinoma averaged 10.5 per cent; their non-toxic, solitary goiters, 18.3 per cent. This compares, in general, with our own statistics.

The accuracy of preoperative diagnoses of carcinoma of the thyroid varies among thyroid surgeons. Majarakis and Cole¹⁰ report that only 46 per cent of their diagnoses are correct, McSwain¹¹ reports only 27 per cent correct, Pemberton¹² and Black² suspected carcinoma in only 40 per cent of their cases, Cattell³ "less than 50 per cent" were correctly diagnosed preoperatively. Cole¹⁰ also reports that 46 per cent of the patients in whom a carcinoma was found presented a goiter preoperatively that was soft in consistency.

With these facts in mind, it certainly behooves us to maintain a high level of suspicion for carcinoma of the thyroid, especially since there is a great degree of selectivity done by the patient, the general practitioner, and the thyroid surgeon. We should further maintain this high level of suspicion, because there are very few symptoms and signs which are sufficiently peculiar to either non-toxic nodular goiters or early carcinoma of the thyroid to be of sufficient value to make a preoperative diagnosis.

In particular, we should advise operation on all

solitary discrete nodules of the thyroid. Many authorities⁶⁻¹⁰ are also advising thyroidectomy for all nodular goiters in order to eradicate suspicious nodules.

Immediate frozen section is imperative in any instance in which there is reasonable suspicion of carcinoma. In particular, any enlarged lymph nodes around the glands should be submitted to frozen section. If this node contains any thyroid tissue, whether it appears to be malignant or not, it has to be considered a metastasis, for true aberrant thyroid tissue is extremely rare.

If adequate frozen sections are not available when dealing with the solitary discrete nodule, the entire lobe and isthmus should be removed because of the high incidence (one in five) of carcinoma.

In dealing with non-toxic nodular goiters, a sub-total thyroidectomy should be done, taking care to remove all of the nodules unless one of these nodules is reported to be carcinoma. If carcinoma is present in the gland, a total thyroidectomy should be done followed by a radical neck dissection on the involved side, and probably a superior mediastinal dissection done. If the malignant disease was not suspected and as a result the patient was not prepared for radical neck dissection, it may of necessity be delayed a few days; on the other hand, if possible, the dissection should proceed at that time in keeping with the tradition and principles of oncological surgery. The entire gland should be removed when carcinoma is present because there is an increased uptake of radioactive iodine by any residual thyroid carcinoma following total thyroidectomy.

Whether the incidence of carcinoma of the thyroid is five per cent or 25 per cent makes little

difference to us as clinicians dealing with individual patients. Whether carcinoma develops in the diffuse toxic, the multinodular, or the discrete nodular is of no real consequence. What is important is that we maintain a high index of suspicion for carcinoma, for any percentage in any gland is too much. The present increasing mortality from carcinoma must be halted. This can not be accomplished by the vigilance of a few—we must have every physician maintain a high index of suspicion for cancer.

478 Peachtree St., N. E.

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Bed, Exercise and Aspirin for Rheumatism

Such old-fashioned treatment as rest in bed, suitable exercises and aspirin "substantially improved" 200 of 282 rheumatoid arthritis patients, and brought 113 of them to "self sufficiency and an active social and economic life," the Arthritis and Rheumatism Foundation has announced.

The report covers a two-and-one-half-year follow-up study of the value of long-term conservative treatment for the disease. Of the 282 patients, 183 were either partially crippled and dependent to some degree upon others or completely crippled and confined to a bed or wheel chair.

Commenting on the modern drugs, the Foundation's report stated that while the results are more dramatic and immediate, they disappear when medication is discontinued. Besides, the various drugs in use today have not shown conclusively that they can alter the natural course of the disease or prevent crippling.

"The importance of sound basic treatment of a conservative nature must not be obscured by the more dramatic effects of new remedies which cannot be maintained with safety to the patient," the report concludes.

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Suggest that beef, lamb, and poultry be roasted or broiled and seasoned with salt and mild herbs.

Meat patties stay tender when crushed corn flakes and a little water are added to the finely ground beef. Salt and a hint of thyme or marjoram give savor.

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Vegetables such as string beans, peas, asparagus tips, spinach and carrots may be cooked and served whole if young and tender. Otherwise they must be puréed. Potatoes may be boiled, baked, or mashed.

Salads of molded gelatin are pretty to look at—better to eat. Your patient may like one made of strained beets livened with lemon juice, chilled and turned out of the mold on shredded tender lettuce.

Desserts add the final fillip. He can try apple-sauce added to whipped lime gelatin, chilled and topped with custard sauce. Or for a party touch, he can sweeten chilled strained fruit, add a squeeze of lemon, and fold into whipped cream or whipped evaporated milk.

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Basic foods requiring primary consideration for providing adequate daily nutrition in such patients are:

"Milk—1 pint; meat—4 ounces; vegetables—2 servings; fruit and fruit juices—3 servings; carbohydrate and fat to fulfill caloric needs.

"In order to restore depleted protein levels, it is necessary to increase the protein component by adding meat servings . . ."¹

Since anorexia usually complicates nutrition in cardiac failure, appetizingly prepared meat encourages adequate eating. The high protein content of cooked lean meat, 25 to 30 per cent, as well as its high biologic value, serves well in mitigating hypoproteinemia and muscle wasting.

Meat also contributes valuable amounts of B vitamins especially needed by the cardiac patient, including both the well-known and the less well-known members of the B complex. Iron, potassium, and phosphorus are among the minerals richly supplied by meat.

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Privine 0.05% Solution in 1-oz. bottles with droppers and in pints.

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(naphazoline hydrochloride CIBA)

C I B A
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**new
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confirms value
of**

Pyribenzamine®

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In the summer and fall of 1953, nine prominent allergists, representing every section of the country except the West Coast, tested Pyribenzamine in a total of 832 patients with ragweed hay fever. The work of these men is significant because of its scope and because it is the most recent major study of antihistamines.

Certain observations are particularly worth noting ... →



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THE ALLERGIC PATIENT...before and one-half hour after receiving PYRIBENZAMINE



**...of the 832 patients who were
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C I B A



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Increases blood flow to the extremities through a direct vasodilating effect on vessel wall, a sympathetic blocking effect, and an adrenolytic effect—

A valuable aid in the treatment of peripheral ischemia and its sequelae—pain, loss of function, ulceration, gangrene, and other trophic manifestations—

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**BILATERAL
ARTERIOSCLEROTIC
ULCERATION** in patient age 65

At start of Priscoline therapy;
ulcer, right leg, $1\frac{3}{4}$ " x $1\frac{1}{4}$ ";
ulcer, left leg, $\frac{1}{2}$ " x $\frac{1}{2}$ ".

With oral Priscoline, 25 mg. four times daily for one week and 25 mg. every three hours thereafter, there was marked improvement in 2 weeks and healing within 6 weeks. No other medication given.



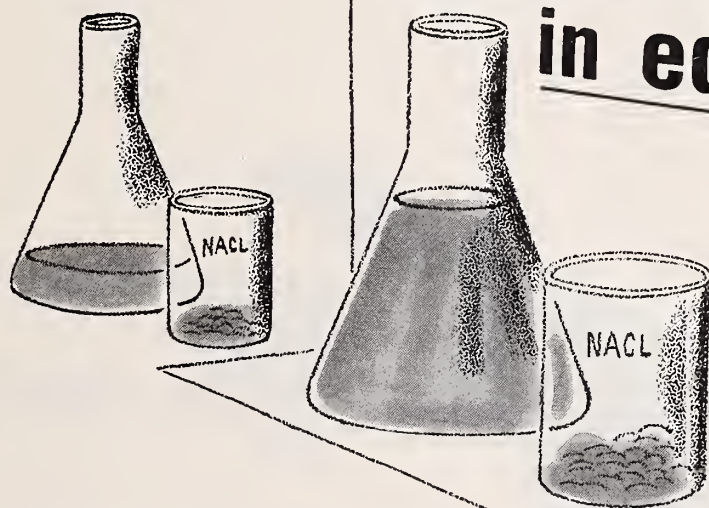
**HYPERTENSIVE ISCHEMIC
ULCER** of right leg in patient

age 65. Ulceration refractory to treatment for 9 months, with patient complaining of severe pain. Treated with oral Priscoline, 50 mg. four times daily for four days and 50 mg. every four hours thereafter. Healing began with onset of Priscoline therapy and was complete in 10 weeks.

PHOTOGRAPHS AND CLINICAL DATA
BY COURTESY OF R. I. LOWENBERG, M.D.,
CONSULTANT IN VASCULAR SURGERY,
CONNECTICUT STATE HOSPITAL,
MIDDLETOWN, CONNECTICUT.

C I B A

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SUPPLIED:

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SALYRGAN[®]-THEOPHYLLINE

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For removal of edema and ascites in cardiac and cardiorenal diseases; nephrosis, and cirrhosis of the liver.

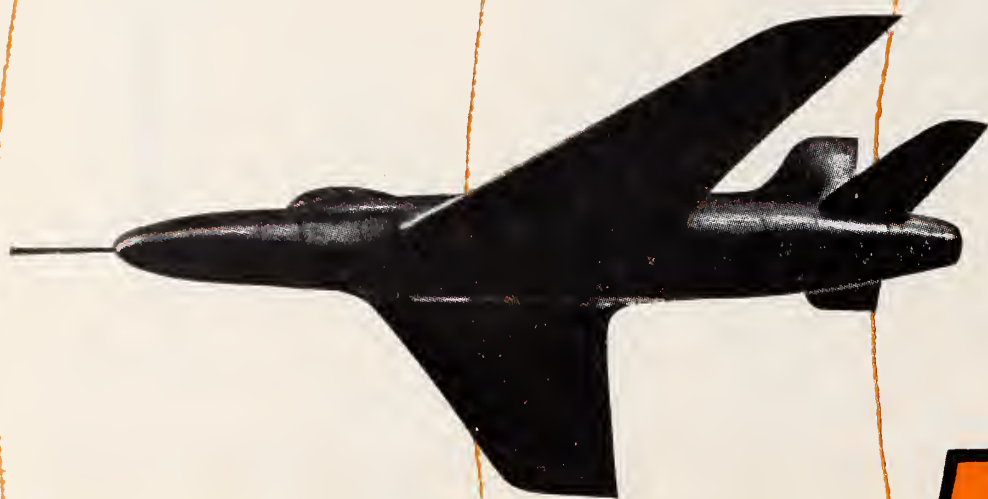
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1. Nielsen, A. L., Bechgaard, P., and Bong, H. O.: Low-Salt Diet in Treatment of Congestive Heart Failure. *Brit. Med. Jour.*, 1:1349, June 16, 1951.

2. Brawn, W. E., and Sutherland, C. G.: Control of Edema in Pregnancy. *GP*, 8:65, Nov., 1953.



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A Case History



Ted F. Leigh, M.D., Guest Editor

IN THE FOLLOWING pages, an effort has been made to give the reader a factual report on the past, present and future of Emory University School of Medicine and to present several scientific treatises by its members. It is hoped that the reader finds the contents interesting and informative.

Having learned something of the school's past through this effort, and having been associated with the school's present, both as a student and staff member for more than half of the last 20 years, I have come to know it fairly well. I offer the following pseudoscientific case report as my own personal appraisal of the school. I can vouch for the authenticity of the facts herein, but I cannot with certainty vouch for the patient's gender, mainly because I have no precedent for a basis.

Case Report

E. U. S. of M. Age 100 years.

Presenting Symptom. Unusual growth recently.

Present History. The patient gives a history of unusual growth and development during the past 15 years. Although she was an elderly lady at the time, and still increasing in size to some extent, the changes in the last 15 years have been far beyond anything experienced previously. She states that she has not only broadened and grown in stature physically, but her mental capabilities have increased as well.

She states that she has had "growing pains" at times, mostly of an acute nature, but none really serious. The pains are sometimes precipitated by such things as financial strain and disruptions in her household.

She has also been plagued with headaches at infrequent intervals throughout her life; she believes that they are no worse than those of any

similar patient. She has had a few more than usual in the past few years, and attributes them to the more complex life that she has led during her period of accelerated growth.

Past History. She was quite a small baby at birth in 1854. Her parents were practicing physicians in the city of Atlanta; they took great interest in her welfare from the beginning, feeding her and housing her as well as possible with their limited finances. With this love and devotion she progressed satisfactorily through these earliest years.

She sustained a fairly severe trauma as a child in 1861, and for four years remained flat on her back; in 1865, she began to recover, and within a short period of time was back to normal.

For many years thereafter, she steadily matured in both mind and body. She has had several marriages during her life time, and with each she acquired a new name; her last was in 1915, at which time she acquired her present name.

Family History. The patient has a very large and loyal family scattered throughout the United States and many foreign countries. Her family have given generously of their time and money and have helped in many other ways as well. They have rallied around her on more than one occasion in time of crisis. She has no complaints relative to them.

Physical Examination. The patient is physically well developed, alert and vigorous, despite her age. She is of muscular build and well coordinated. Her recent growth is apparent, but since it is well distributed is not unbecoming to her. There is no visible indication that it will not continue. All of her systems appear to be in good order and functioning well.

Her mental outlook is young despite her age; an indication of this mental youthfulness is shown by the fact that she looks more to her future than to her past.

Summary. From the history and physical examination, it is apparent that the patient is in excellent health. The recent growth which she has experienced becomes her, and from all indications it is likely to continue. There is no reason why she can not live for another 100 years. Any estimate of her appearance in the year 2054, however, would be entirely speculative.

The First Hundred Years

1854

On February 14, 1854, the General Assembly of Georgia granted a charter for the Atlanta Medical College to a group of trustees.

1855

The first session ran for four months, May through August of 1855, with classes held in the Atlanta City Hall (the site of the present capitol). The 78 students enrolled attended five lectures daily from 8 a.m. to 1 p.m.

Two members of the faculty, J. G. and W. F. Westmoreland, operated an infirmary, and the college held one medical and one surgical clinic each week providing some practical instruction.

The faculty began the publication of the *Atlanta Medical and Surgical Journal*.

1856

Largely as a result of the efforts of J. G. Westmoreland who served as dean, treasurer and chairman of the building committee, a large building of two stories and basement containing three lecture rooms, an amphitheatre and a dissecting room was ready for the session beginning in May, 1856. The building was located on the present site of the Negro Division of Grady Hospital.

1857

John G. Westmoreland, Dean and Professor of Principles and Practices of Surgery, was elected to the Legislature for the purpose of securing an appropriation to complete the medical college. The \$15,000 grant made by the state relieved the immediate indebtedness of the college. In return the college agreed to accept each year one young man from each of the state's congressional districts. Hundreds of young men have received medical educations as a result of this agreement.

1858

Members of the faculty were asked to contribute original matter to the *Journal*, in regular rotation, one member contributing something each month.

1860

The faculty voted to increase the number of clinics from one medical and one surgical clinic to three medical and three surgical clinics each week.

1861

On July 3, J. G. Westmoreland moved that the lectures be suspended on the morrow. What was apparently the last faculty meeting until after the Civil War was held on August 6, 1861.

1865

The first faculty meeting after four years of war was held on August 16, 1865.

The college session was changed from summer to winter. The next regular course of lectures was to begin on the first Monday in November.

1866

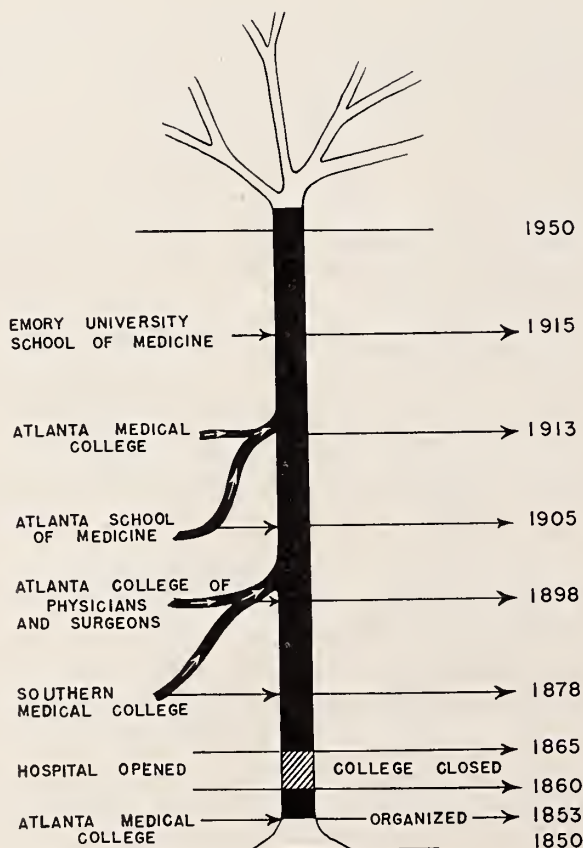
The city of Atlanta donated \$5,000 in city bonds "to be used in repairing the building and in refurnishing the institution with the necessary appliances and apparatus . . . which were lost and destroyed during the late war."

1868

The Honorable Mr. Alexander H. Stephens was requested to act as valedictorian on the part of the Faculty on Commencement occasion and General John B. Gordon was chosen as his alternate.

1869

A committee of three was appointed to request the Trustees to allow the City Council a sufficient amount of the college lot on which to erect a city Hospital.



1872

The faculty asked the Trustees to request that the Legislature amend the charter to allow the College to confer the Degree of Doctor of Pharmacy.

A. W. Calhoun, Professor of Anatomy, and V. H. Taliaferro, Professor of Diseases of Women and Children, were elected to the faculty.

1873

The faculty arranged with W. F. Westmoreland to assume the publication of the *Atlanta Medical and Surgical Journal*.

1874

H. F. Scott was appointed Professor of Anatomy, J. B. Baird, Lecturer on the disorders of the mind and nervous system, and J. T. Johnson, Lecturer in a special course on venereal diseases.

1876

The Dean, in his annual report, stated that a clinic with hospital accommodations for a limited number of patients was being carried on regularly at the expense of the faculty.

T. S. Powell organized the Southern Medical College. The following, in addition to Dr. Powell, were members of the faculty during the existence of the college: W. P. Nicholson, G. G. Roy, J. M. Gaston, W. S. Elkin, J. C. Olmstead, H. F. Harris, Dunbar Roy, F. W. McRae, James A. Gray and J. B. S. Holmes.

1879

Expensive improvements and additions to the building were made during the year. The faculty had expended nearly \$1,000 in prescriptions furnished gratuitously to the poor.

1880

Forty-eight students received diplomas on March 3, 1880, at the commencement exercises held at DeGive's Opera House, the largest class since the war.

1881

The faculty adopted resolutions on the resignation of John G. Westmoreland, "oldest officer, venerable founder, one of ablest teachers, safe, wise counsellor, general companion and a most noble gentleman".

1883

H. V. M. Miller suggested that proctor request J. B. Baird to act with the faculty in trying to get a dissecting law passed by the next legislature.

1887

The faculty passed a resolution favoring the establishment of a hospital in the city of Atlanta. The death of V. H. Taliaferro, former Dean, at

Tate Springs, Tennessee, was announced on September 10, to the faculty.

1888

A committee was appointed to confer with Southern Medical College of Atlanta and with Augusta Medical College in regard to raising fees to 105 dollars per session.

The question of putting a refrigerator in the dissecting room was left to the discretion of Armstrong and McRae.

1890

W. F. Westmoreland was unanimously recommended to the Board of Trustees to fill the Chair of Surgery made vacant by the death of his distinguished father.

1891

W. F. Westmoreland and W. S. Kendrick were appointed to look after the interests of the Atlanta Medical College in regard to proper representation in the Grady Hospital.

1893

The Proctor's Report for the 35th annual session, 1892-1893, stated that the total enrollment was 183 students, 172 medical and 11 pharmaceutical. Collections amounted to \$18,110.00, an increase of \$1,500.00 over the previous year.

1895

The faculty voted to put a telephone in the building. They also voted unanimously not to matriculate graduates of Eclectic, Homeopathic and other such institutions or admit them to advanced classes in Atlanta Medical College.

1896

This year the first class graduated under the three years' rule.

1897

The Dean's Report for the 1896-1897 session stated that attendance was up 10 to 20 per cent, that the bacteriological laboratory had been of material benefit to the school and that the outlook for the future was promising.

1898

The Atlanta Medical College and the Southern Medical College combined to become the Atlanta College of Physicians and Surgeons.

1900

Dean Kendrick reported to the Board of Trustees that the "endless entanglements and embarrassing contingencies incident to the coalition" had been passed through successfully and that the flourishing condition of the school showed the wisdom of the consolidation.

Of the 265 medical students, 187 were from Georgia, three from Wisconsin, one from each of

the following states and foreign countries: Ohio, Pennsylvania, California, Cuba and India. The remaining 70 were from other southern states.

1901

The requirements for an M.D. degree were raised to four years.

1902

According to the Dean, the facilities for scientific research and for outdoor clinical work were "probably not equaled south of Baltimore".

1903

The first graduates under the four-year system received diplomas at the Commencement at the Grand Opera House on March 30.

1905

The Board of Trustees made plans to replace the main building of the old Atlanta Medical College with a new and more adequate one.

W. S. Elkin became Dean of the Faculty.

1906

Dean Elkin reported that the college had enjoyed a very successful year. The Board of Trustees accepted his suggestion that a chair to be known as the Andrew Carnegie Institute of Pathology be established in honor of Mr. Carnegie in appreciation of his gift of \$10,000.00 to the College of Physicians and Surgeons. A like honor was conferred on A. W. Calhoun, who gave \$10,000.00 towards the fund for the new building, and the Abner W. Calhoun Chair of Clinical Ophthalmology was established.

1907

Of the 200 medical students, 125 were from Georgia, 65 from other Southern states, and one from each of the following: New York, Cuba, Mexico, Puerto Rico, and Russia.

1910

The Committee on College matters, on July 14, 1910, recommended "in order to keep abreast with the other great medical colleges," the Board elect full-time, paid professors for the Chair of Anatomy, Embryology and Histology at a salary not to exceed \$3,000 per year, for the Chair of Physiology at the same salary and for the Chair of Chemistry at \$2,000 a year, as well as an Adjunct Professor of Bacteriology and Hygiene and Demonstrator of Pathology and Bacteriology, full time at a salary not to exceed \$1,500.

1912

Entrance requirements for the coming session were raised by the adoption of the 14-unit requirement for admission.

1913

The Freshman class enrollment dropped from

141 to 65 because of the higher entrance requirements.

The Board of Trustees, April 7, 1913, passed a resolution regarding with favor "the suggestion of consolidation of the Atlanta College of Physicians and Surgeons and the Atlanta School of Medicine".

Dr. Elkin, who continued as Dean of the consolidated college, reported that Grady Hospital Trustees had passed a resolution granting privileges to the faculty which would very likely "help a great deal in getting us rated as a Class 'A' school by the Medical Council of The American Medical Association".

1915

Dr. Elkin, on January 6, 1915, brought to the attention of the board "a movement of much moment—the union of the College with Emory University".

Students, in sections, were given permission to study tuberculosis at Battle Hill. Beginning with the next Spring term, each Sophomore was to be required to have a clinical kit consisting of stethoscope, thermometer, flashlight and reflex hammer.

As part of the agreement made in the merger the University pledged to appropriate \$250,000 to endow the School and to build a new Hospital to enlarge the teaching facilities.

1916

The faculty sought to arrange for more autopsy work, especially for the Seniors.

Members of the faculty were requested to wear caps and gowns for the commencement exercises. Upon being informed that the price for caps and gowns would be from \$50 to \$58, the faculty voted to defer the question to a later time.

1917

The War Department gave the college the privilege of organizing a Base Hospital.

The John P. Scott Laboratory of Anatomy and the T. T. Fishburne Laboratory of Physiology were completed. In September, instruction in the first two years of medicine was moved from the downtown medical plant, and provision was made for freshman and sophomore medical students in Dobbs Hall.

1918

Seniors with an average of 80 per cent were permitted to enlist for immediate active duty without examination at the urgent request of the Army and the Navy.

1920

On January 20, 1920, the Dean "outlined the

plan under consideration for the establishment of a hospital on the campus; this present building being offered to the city for a colored hospital”.

1921

The Dean reported a teaching staff of 100, of whom 14 were full-time professors, instructors and technicians, connected with the fundamental branches, with salaries varying from \$1,200 to \$3,600 per year. Those connected with the clinical branches received no remuneration.

1923

In June, 1923, the Dean reported that the Negro Division of Grady Hospital with approximately 240 beds, constantly full, was a most valuable teaching unit. Births in this hospital averaged about 70 per month.

In September, Dr. Elkin pointed out that the Wesley Memorial Hospital, which “was designed primarily for a teaching hospital”, had been forced on account of finances to close its charity wards and thus reduce to a minimum its value to the medical school.

In October, F. Phinzy Calhoun’s generous gift of \$10,000 to the library of the medical school was announced. The new library would be known as the A. W. Calhoun Medical Library, in memory of Dr. Calhoun’s father.

1925

On June 8, Alumni Day, three or four hundred alumni were expected to be present “to receive the new Emory University diploma in exchange for one received from some school that is now merged into the University.

W. S. Elkin resigned as dean and was succeeded by Russell Oppenheimer.

1927

The School of Medicine graduated 42 students of whom 39 entered hospitals for the fifth or interne year, a practice which was becoming more and more necessary for the successful physician, and one which some schools were requiring for graduation.

1928

The Emory University division of Grady Hospital remained the principal clinical teaching unit of the school. The custom of the year before of sending sections of seniors to Wesley Memorial Hospital for instructions with white patients was continued. Medical students were given access to the clinical material of the Steiner Clinic and had the opportunity of instruction by highly trained personnel and acquaintance with the excellent equipment of the clinic.

1929

“As a result of the inspection this year by the Council on Medical Education and Hospitals of the American Medical Association, the Emory University division (colored) of Grady Hospital was listed as a separate institution for the training of internes and residents.”

1930

The Dean pointed out that the objective of establishing a correlation between the fundamental and the clinical years had been attained to some extent by advancing the beginning clinical instruction into the first and second years of the curriculum.

1932

During the past session, medical instruction was extended to the wards of the white hospital at Grady.

1933

A procedure for interviewing all prospective students of the School of Medicine in order to avoid “certain unfortunate choices made in past years” was worked out.

The dean proposed, in spite of the financial stringency, that a definite sum be designated as a research fund.

1934

Of the 60 seniors who graduated in June 1934, one entered the United States Public Health Service and the remaining 59 entered approved hospitals for internship.

1937

The Dean’s Report read in part: Funds were still needed for the payment of part or full-time faculty and for research. As to research, it was needed for the development of new knowledge and even more for “the establishment and maintenance of the atmosphere of vitality essential for effective teaching.

The Robert Winship Memorial Clinic for the study and treatment of neoplastic diseases was opened in June in the Emory University Hospital, with J. Elliott Scarborough as its director.

During the year the University bought one-and-a-half blocks of land adjoining Grady Hospital in downtown Atlanta for “possible future development of the School of Medicine”.

1938

A Planning Committee was appointed by the President to consider the future organization, development and work of the School of Medicine.

With the beginning of the session, 1937-1938, requirements for entrance to the school of Medicine were advanced from two years to three years of premedical work.

1940

Luther C. Fischer deeded his \$1,000,000 Crawford W. Long Memorial Hospital to Emory, the gift to become effective upon his death.

Alpha Omega Alpha, medical honor society, installed an Emory Chapter.

1941

The policy of organizing the teaching staff of all clinical departments around a nucleus of full or part-time teachers began to be carried out in the Department of Surgery. Gifts already received had made it possible to begin plans for extending the policy into the Department of Medicine.

The Joseph B. Whitehead Foundation gave \$550,000 to erect and equip the Conkey Pate Whitehead Surgical Pavilion.

1942

General Hospital No. 43 was organized from members of the medical school faculty. Full-time members of the faculty assumed, without extra compensation, the additional load placed upon them by the accelerated program.

1943

Students accepted the accelerated program willingly and in most instances met, without difficulty, the demands made upon them by a continuous curriculum. Funds for student loans made available by the University, the Kellogg Foundation (\$10,000), the federal government and other sources eased the financial strain.

1944

During the year a single staff was created at Grady Hospital, eliminating the separate staff for the white and colored units. This reorganization was a decided advantage to the school.

1945

Eugene A. Stead, chairman of the Department of Medicine, was made Dean of the School, succeeding Russell H. Oppenheimer who had held the deanship for 20 years.

After receiving a grant of \$167,100 from the National Foundation for Infantile Paralysis, the medical school planned to establish a Department of Physical Medicine. This department began to function in the fall of 1946.

1946

R. Hugh Wood succeeded Dr. Stead as dean of the School of Medicine.

Graduate and undergraduate teaching programs at Emory Hospital were greatly enlarged during the year. For the first time fourth year students were taught medicine and surgery, neoplastic diseases and roentgenology at the University Hospital.

The Faculty of the Medical School agreed to assume the responsibility for a portion of the professional services at Lawson Veterans Administration Hospital.

In March, 1946, the first postwar class of more than 200, including the "accelerated" physicians and dentists, was graduated. At that time, Elizabeth Gambrell, Atlanta, received her fourth degree, the first M.D. ever awarded by Emory to a woman.

1948

The critical admissions problem was eased to some extent when an anonymous donor made it possible for the school to accept 72 freshmen instead of the customary 60. A Reserve Officers Training Corps unit for medical students was established.

1949

The Ph.D. program, already offered in chemistry and biochemistry, was extended this year to the fields of anatomy and biology.

James E. Paullin, Professor of Clinical Medicine, retired.

The Dean reported that the sum of \$350,000 provided by outside foundations and agencies was being expended annually for research and teaching.

1951

The most outstanding accomplishment during the year was the construction of the laboratory and research building.

A grant from the United States Public Health Department and the Georgia Health Department made possible the planning, now underway, for the establishment of a clinic for obstetrical patients with complicating diseases at Grady Hospital.

1952

In December, 1952, the Executive Committee of the Board created a Health Service Board composed of the following persons: Mrs. James D. Robinson, Chairman, Mr. William N. Banks, F. Phinzy Calhoun, Sr., Mr. C. Howard Candler, Jr., Mr. James V. Carmichael. These men were appointed to act for the Board of Trustees in all matters relating to the health services.

Mr. Boisfeuillet Jones was designated Acting Administrator of the Health Services. Arthur P. Richardson was appointed Director of the Basic Sciences in the Health Services. R. Hugh Wood, Dean of the School of Medicine, was named director of the Emory University Clinic.

1953

The Glenn Memorial Building was completed and several departments of the school as well as

the downtown office of the dean and the Grady branch of the A. W. Calhoun Medical Library are now housed there.

Aidmore Hospital, whose program will be integrated with that of the School of Medicine, moved to the campus and became the first independent community enterprise to join with Emory in its new medical-center development program.

William L. Caton became professor and chairman of the Department of Obstetrics and Gynecology, the first full-time chairman of this department.

Daniel C. Elkin, distinguished Joseph B. Whitehead Professor of Surgery, Chairman of the Department of Surgery and Surgeon-in-Chief of Emory Hospital, announced he would retire in June 1954 or before.

The Georgia Heart Association granted the medical school \$12,000 a year for the establishment and maintenance of a chair of cardiovascular research, to which sum Emory will add \$3,000 more.

The Emory University Clinic was organized with R. Hugh Wood, Dean of the Medical School, as its Director.

Centennial Celebration Program

Monday, October 4, 1954

- 9:00 REGISTRATION OF ALUMNI AND VISITORS,
Glenn Memorial Auditorium
- 10:00 MEDICAL ADDRESSES, *Glenn Memorial Auditorium*
Dr. Alfred Blalock, Professor of Surgery,
The Johns Hopkins University
Dr. John F. Fulton, Professor of Physiology and Professor of the History of Medicine, Yale University
Dr. Stanhope Bayne-Jones, Director of Research of the Medical Department of the United States Army.

- 12:30 LUNCHEON, *University Gymnasium*
Alumni, faculty and all persons attending the program are invited.
- 2:00 MEDICAL ADDRESSES, *Glenn Memorial Auditorium*
Dr. Cyrus W. Sturgis, Professor of Medicine, University of Michigan
Dr. Evarts A. Graham, Professor of Surgery, Washington University
- 4:00 TOURS OF THE SCHOOL OF MEDICINE AND THE CAMPUS
- 6:00 RECEPTION FOR ALUMNI, *Atlanta Biltmore Hotel*
- 7:00 MEDICAL ALUMNI ASSOCIATION BANQUET, *Atlanta Biltmore Hotel*

Tuesday, October 5, 1954

- 10:00 CENTENNIAL CONVOCATION CEREMONIES,
Glenn Memorial Auditorium
ACADEMIC PROCESSION
University officers, distinguished guests, representatives of schools of medicine and

- medical societies, the faculty of the School of Medicine
CONVOCATION ADDRESS
Dr. Alan Gregg, Director of Medical Sciences and Vice-President of the Rockefeller Foundation
- 12:15 LUNCHEON, *University Gymnasium*
All persons attending the Convocation Ceremonies are invited.

Interview — with R. Hugh Wood, M. D.

Dean, Emory University School of Medicine

The Dean's Job

Q—How long have you been Dean of Emory's Medical School?

A—Eight years this August.

Q—What were you doing before that time?

A—Private practice in internal medicine in Atlanta and voluntary teaching in the medical school; immediately prior to becoming Dean, I was in military service.

Q—Between private practice and being Dean—which is more difficult?

A—I would say being Dean is the more difficult. I had a good deal of formal training for private practice, but none for the job of being Dean.

Being Dean of any medical school is a very complex and difficult assignment. One is not only expected to have some knowledge of medical education, planning curriculum, recruiting and keeping faculty, but one must also at the same time plan budgets, develop facilities in the physical plant and carry on all the complexities of administration.

Q—Does your job require any activities outside the medical school?

A—There are a number of extramural activities. The Dean is expected to be the school's representative to the Alumni, to the Tuberculosis Association, Red Cross and similar health agencies.

Q—It seems to me that a Dean must have special qualifications for his job. Could you name some?

A—He certainly should. First, he should have come up through the ranks as a teacher in medicine, either in a clinical or preclinical department. Second, he should have had experience or training in administration and organization.

Q—Could you briefly describe one of your typical days?

A—Yes, I come to the office in the Woodruff Memorial Building, look briefly over accumulated

mail and answer any letters that require immediate reply, interview one or two students, either candidates for admission to the medical school or students who have a scholastic or personal problem. Next, see one or more faculty members concerning a pending research grant or the employment of additional instructors. Then I go to lunch at Emory University Hospital where, on an average, I see some two to four of the faculty members or staff of the hospital about school matters.

Q—Do you think that's good for your digestion?

A—Not very, but it can't be helped. In the afternoon I am likely to attend a meeting of the Service Chiefs at Grady Memorial Hospital and later stop at a meeting of one of the health agencies on the way home. Several times weekly there will be meetings at night to attend.

Q—Speaking of Grady, I believe you have a new building down there.

A—The building to which you refer is the Glenn Memorial Building, laboratory research and office space for those members of the faculty based at Grady.

Q—What departments does that include?

A—Chiefly medicine, surgery, pediatrics and obstetrics.

Q—How much of the student's time in the clinical years is spent at Grady?

A—A great deal—the majority—seven-eighths of the last two years. In addition to that the sophomores are there for physical diagnosis. The remaining time is spent at the VA Hospital and Emory University Hospital.

Q—When the new Grady is finished, will there be any significant alterations in the teaching program?

A—No basic alterations in the program except that we will have a much more adequate physical plant for out-patient service, and an increase to

1,000 in the number of beds from the present number of little over 600.

Q—Crawford W. Long Hospital is owned by Emory, isn't it?

A—Yes, it is.

Q—Is there any teaching done there now?

A—There is approved resident training in all the major divisions but no undergraduate teaching.

Q—Are there plans for student training there in the future?

A—No concrete plans are in line at this time. Another important function that this hospital will play in the doctor's medical program is that it will be a conveniently located private hospital where the volunteer faculty members may have their patients.

Q—How is the new Emory Clinic coming along?

A—I would say that it is progressing most satisfactorily. There are now about 20 doctors with their offices in Emory University Hospital.

Q—Are they teachers on the medical school staff?

A—Yes, they are. The members of the Emory Clinic are all on the faculty.

Q—Is the purpose of the Clinic to furnish medical faculty primarily?

A—Yes, indeed. That is the primary purpose; however, in addition to providing clinical teachers who earn the principal part of their own income, these clinic members pay to the University for the general medical school budget the equivalent of the income on one and one-half million dollars of endowment at the present time.

Q—That's a great deal of money, isn't it?

A—It certainly is. When one considers that the instructional budget of the medical school is \$660,000, then the amount produced by the clinic is roughly 10 per cent of the total.

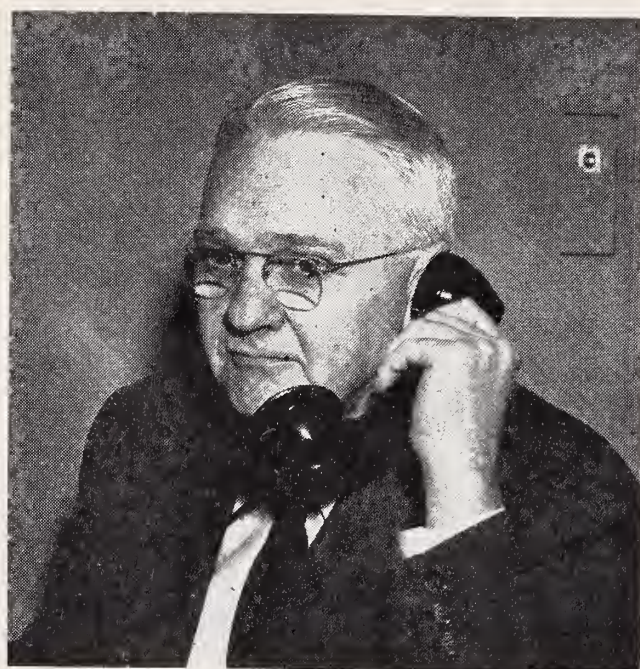
Q—Speaking of that, what is the present financial position of the medical school?

A—In one sense it is much better than it has ever been; we were formerly dependent upon annual gifts for about one-third of our support; we now have an endowment which replaces certain annual gifts.

Q—Is there any source of income other than endowment and tuition?

A—Yes, there is. The other sources of support are through the Southern Regional Education Board and the American Medical Education Foundation.

Q—What is the Southern Regional Education Board?



R. Hugh Wood, M.D.

A—This is a board which was set up by the governors of the southern states. Through this medium various states which have no medical schools pay a certain amount per student per year to the school in another state for legal residence.

Q—What states does this board include?

A—This Board, as I say, includes all the southern states; however, Florida is the principal state from which Emory Medical School receives support. We receive \$1,500 per student per year from this state—this amounts to \$100,000 per year.

Q—Aren't they planning their own medical school?

A—Yes, at the University of Florida; it is scheduled to open September 1, 1955.

Q—Will that affect Emory?

A—It probably will. It is thought that Florida will cease these payments after the medical school is established.

Q—Will applicants from Florida still be accepted?

A—Yes, they will.

Q—You also mentioned the American Medical Education Foundation. Can you tell us about that?

A—That was pretty well explained in the August issue of the *JMAG*. Essentially it is a foundation to help students through medical school.

Q—How does Emory's budget compare with other U. S. medical schools?

A—That is a difficult question to answer since most medical schools release no exact information,

and even when they do the figures from different schools are not made out on the same basis. However, from our best source of information, Emory is in the upper third. However, this does not mean that Emory is well off—rather it reflects how poorly supported most medical schools are.

Q—How does the Emory tuition compare with that of other schools?

A—Emory's tuition of \$800 per year is near the national average. Very few charge more while some schools—particularly the State schools—charge much less.

Q—What do you figure it costs to educate a medical student?

A—That can easily be answered by dividing the medical school's budget by the total number of medical students. In Emory's case, it comes out in excess of \$3,000 per student per year.

Q—Does all that figure represent student education?

A—No, it does not, because the medical school is also participating in the training of some 200 internes and residents in its teaching program.

Q—What does it cost each student per year to attend school?

A—As nearly as we can calculate, the student spends not less than \$1,800 per year.

Q—Then this means that only rich men's sons can become doctors.

A—If the situation is not relieved, it might tend in that direction which must not be allowed to happen. The only safeguard is the provision of more scholarships for deserving and needy students.

Q—Do you have any such scholarships at Emory?

A—Yes, we have a certain amount of money in the form of scholarships. At the present time, it amounts to \$8,600 which is divided among 16 students. The amount of each scholarship varies from \$400 to \$1,000 per year.

Q—Are you getting well qualified applicants for medical school in spite of the high cost of education?

A—Yes, we are. We had 650 applicants last year.

Q—What per cent are from Georgia?

A—I do not have the exact figure of how many are from Georgia, but would estimate that roughly one-half are Georgia residents. The majority of Emory medical students are from the southeastern states, but we may and do take well qualified candidates from any state in the United States.

Q—How are these candidates selected?

A—We have an Admissions Committee which works hard on this problem. We consider several points—grades from the college attended, the Medical College Admission Test Score and the recommendations of the college faculty; the last is one of the most important factors in making the decision, particularly if we can get a critical evaluation of the student.

Q—Do you interview these applicants personally?

A—Yes. We have a personal interview with all students whom we are seriously considering. Some are eliminated by examination of their grades and tests. In a few instances, for the student living at a distance from Emory, a representative of the school may conduct the interview and report to us.

Q—Do all these methods amount to a foolproof system of selection?

A—No. It is the best we have been able to devise; however, it is practically impossible to determine what students will make the best doctors, and in spite of our careful selection some fail.

Q—How many?

A—We lose an average of five or six students out of each class during the four years.

Q—Do you mean you flunk seniors?

A—Rarely. We usually fail about three students in the freshman year, two in the sophomore and occasionally juniors.

Q—Are most of the students interning in the South?

A—Yes, the majority do. However, it is not limited to the South. Many of our students go to the eastern and mid western hospitals.

Q—Have you any figure on what per cent locate in the south?

A—No, we do not. Such an estimate should be made. We do know from previous surveys that the young doctor is likely to locate in the community where he serves his last hospital appointment.

Q—Have you any figure on the number of Emory men who enter a specialty?

A—No, we have no exact figure, but about 50 per cent of the members of each senior class in the last five years have indicated at that time that they planned to enter general practice.

Q—Since there seems to be a shortage of doctors, why don't you increase your enrollment?

A—That is a good question. As a matter of fact, Emory did increase its enrollment about 20 per cent—from 60 to 72 students—in 1948. We have now reached our optimum size. To increase

enrollment further would necessitate not only an increase in the budget and the size of the faculty, but also in the physical plant as well.

Q—You mentioned faculty just now; how many full time men do you have on your staff?

A—There are approximately 40 full time salaried faculty members at the present time. In addition to this, there are another 15 members who receive part time remuneration; then the members of the clinic add another 20. They are considered as “geographically full time”. This is at least four times as many as the school had in 1940.

Q—Do you find it difficult to secure well qualified teachers?

A—We certainly do—and so do all medical schools—mainly because of the salaries which medical schools are able to pay as compared to

what qualified people may earn in private practice—or as scientists in industry; all too few well qualified men go into academic medicine.

Q—What categories are most difficult to fill?

A—Those of physiology, pharmacology, pathology and anatomy.

Q—The basic sciences, so to speak?

A—Yes. These are the short categories, but by no means the only ones. It is also difficult to secure top flight clinical teachers.

Q—In closing, would you mind summarizing Emory’s progress up to date?

A—Emory Medical School has certainly made tremendous progress in the past 12 years; however, at that time it started out with so very little in the way of staff, budget and facilities that we still have a long way to go before we reach our ultimate goal.

Facilities of Emory University School of Medicine

Woodruff Memorial Building

An eight story building with six story wing, on the campus, containing approximately 120,000 square feet, 92,000 of which are completed and in use. It houses the administrative offices of the School of Medicine; the departments of bacteriology, biochemistry, and pathology; the Abner Wellborn Calhoun Medical Library; medical illustration and photography; animal rooms; and research facilities for medicine, surgery, psychiatry, radiology and for coordinated cancer research. Within the next several years it is planned that the space not now used will be completed to accommodate the Department of Pharmacology, now housed in the physiology building, and additional facilities for research by clinical departments.

Anatomy Building

A four story building on the campus containing approximately 25,000 square feet. It houses the Department of Anatomy.

Physiology Building

A four story building on the campus containing approximately 25,000 square feet. It houses the

Department of Physiology and, temporarily, the Department of Pharmacology.

Emory University Hospital

A general hospital on the campus with 320 beds and well-equipped service facilities. Twenty doctors engaged in the group practice of medicine as members of the Emory University Clinic, includ-



ing the Robert Winship Clinic for neoplastic diseases, are housed in the hospital pending construction of a new clinic building on the campus directly across the street from the hospital. This is a teaching hospital and an integral part of the medical education program. It serves private patients, for the most part, with limited support for service patients. It supplements for clinical teaching the community's charity hospital.

Emory University Clinic

Plans are being drawn for construction within 18 months of a diagnostic and treatment center to house geographically full-time members of the Medical School faculty engaged in the private group practice of medicine. These faculty members are organized as the Emory University Clinic, under a partnership agreement and use facilities of the School of Medicine under a contract between the partnership and the School. They support themselves by serving private referral patients while contributing both time and money to teaching and research activities of the School. The new building will house approximately 40 doctors and an equal number of fellows. It will be located directly across the street from the Emory University Hospital, connected to the hospital by an underground passageway, and will be an important keystone in support of the School.

Crawford W. Long Memorial Hospital

A general hospital in Atlanta with 550 beds and complete service facilities, owned and operated by Emory for private patients. The professional staff is open to practitioners of the community, many of whom are volunteer members of the medical faculty. The hospital conducts a postgraduate teaching program under the general supervision of the School of Medicine.

Grady Memorial Hospital

A general hospital in downtown Atlanta with 700 beds and 350,000 annual out-patient visits, owned and operated by the Fulton-DeKalb Hospital Authority as the community hospital for the two counties, supported as to patient care by local tax funds. The School of Medicine has responsibility, under a contractual arrangement with the Hospital Authority, for professional service in the hospital. This is the major center of clinical teaching for the School. The Hospital Authority has begun construction of a new 1,000 bed hospital to replace the present facilities; it is to be completed in 1957 at a total cost of approximately \$23,000,000.

Thomas K. Glenn Memorial Building

A five story building adjacent to Grady Memorial Hospital in downtown Atlanta containing approximately 38,500 square feet. The building, a gift of the Wilbur Fisk Glenn Foundation to the Fulton-DeKalb Hospital Authority to provide headquarters for the Emory School of Medicine at Grady Hospital, has been completed within the past year. It houses medical school administrative offices; offices, laboratories and classrooms for the four major clinical departments of medicine, surgery, obstetrics-gynecology and pediatrics; a branch of the medical library; a student lounge and locker rooms.

Atlanta Veteran's Hospital

A general hospital in Atlanta with 300 beds operated by the Veterans' Administration. Professional service in the hospital is supervised by a dean's committee of the School of Medicine, and the hospital supplements clinical teaching carried on at Grady and Emory Hospitals.

Related Independent Health Service Facilities

Emory University has approved a policy encouraging the location in the general campus area adjacent to the School of Medicine of such independent community health service facilities as may properly be related to a medical school and which may wish to be so related.

The Elks of Georgia are now completing construction of a new plant for Aidmore, a convalescent hospital for crippled children, on a site acquired from the University adjacent to the School of Medicine. This hospital has 72 beds and also provides for out-patients. It is owned and operated by the Elks of Georgia, and its professional policies will be correlated with the program of the School of Medicine. It will serve as a supplemental facility for clinical teaching.

The Federal Government owns a 15 acre tract near the campus and has completed plans for construction of a Communicable Disease Center of the Public Health Service. It will be composed of six buildings costing approximately \$13,000,000. Appropriations have not been made for construction of this facility.

Independent health service agencies have discussed the possible location near the School of Medicine of such other facilities as a community hospital for private patients, a children's hospital, a rehabilitation center and a home for the chronically ill and aged. No plans are definite regarding any of these.

Research in Emory University

School of Medicine

RESearch IS THE lifeblood of any medical school; Emory is no exception. Currently many projects are underway; a few of these are abstracted below.

Acute Arterial Injuries

A review of the acute arterial injuries occurring at Grady Memorial Hospital in Atlanta has demonstrated that the length of time from injury to repair is perhaps the most important single factor in determining the fate of the involved extremity. Diagnosis of arterial injury is usually obvious. Following the diagnosis, control of hemorrhage, replacement of blood volume and adequate surgical exploration are always necessary. Arterial injuries were classified as contusions, lacerations, incomplete severances and severances. The treatment depended upon the type of injury. Severe contusion required resection, laceration and incomplete severance usually could be repaired. Complete severance could usually be anastomosed primarily after adequate mobilization. However, vein grafts were occasionally necessary. Anticoagulants in the post-operative phase did not prove helpful.

Department of Surgery

Detection of Steroids

Two grants make possible research into the detection of steroids in urine and tissues. One grant is designed to provide information on the action of certain drugs which tend to inhibit the adrenal cortex and to determine if alteration in steroid pattern occurs during alteration of function. The other is designed to provide information regarding the ability of cancerous tissue to metabolize steroids as compared to this ability in normal tissue. Both grants involve similar objectives in some respects, as it is necessary to develop new techniques to detect steroids of various types. At present new techniques have been developed for 17-hydroxy and 17-ketosteroids in blood and urine. Paper chromatography has been utilized to determine the alteration of pattern of steroids

under the influence of various experimental procedures.

Department of Physiology

Cobalt 60 Teletherapy

Radioactive cobalt 60 may be utilized as a convenient source of high energy radiation similar in quality to that produced by two to three million volt x-ray generators. The present project initiated in 1953 has at its scope the development and evaluation of a small cobalt 60 teletherapy unit for the treatment of malignant tumors. The teletherapy unit was designed in 1953, and as a result of this project construction of the unit is now nearing completion by the engineering experiment station of the Georgia Institute of Technology.

In the early phases of this study the physical characteristic of this apparatus and its radiation beam will be studied. The adaptability of the equipment to various forms of clinical cancer therapy will be determined. In later periods of the project clinical results will be evaluated and further technical improvements be considered.

Departments of Radiology and Surgery

Erythroblastosis Fetalis Due to A-B Isoimmunization

Through this study, it is hoped to determine:

1. The true incidence of erythroblastosis fetalis due to A-B isoimmunization.
2. If this disease can be accurately predicted prior to birth by maternal antibody titers.
3. The severity of erythroblastosis fetalis due to A-B isoimmunization.
4. The frequency of kernicterus associated with erythroblastosis fetalis due to A-B isoimmunization.

The incidence of erythroblastosis fetalis due to A-B isoimmunization has not been adequately determined. So called physiological icterus, in some instances, may be due to this mechanism. Some of the deaths in premature infants attributed to various causes may actually be due to kernicterus following A-B isoimmunization. An effort will be made to clarify some of these points.

Department of Pediatrics

Radiation Effects on Cells and Tissues

In collaboration with the Naval School of Aviation and Medicine in Pensacola, Florida, studies are being made relative to the effects of internally administered alpha radiations on cells and tissues. It is hoped that the information obtained from this study will have a bearing on the effects of cosmic radiation encountered at high altitudes.

Department of Pathology

Psychotherapy

One phase of this work has been the study of the effectiveness of psychological methods of treatment with so-called "deteriorated schizophrenic patients". This has included an effort to better understand the psychological factors in the pathogenesis of this disease. Because of the interest of this department in a closer relationship between psychiatry and medicine, it is attempting to quantitatively measure the effectiveness of the use of a limited psychotherapeutic approach by the general practitioner. This involves the statistical evaluation of some of the measurable ways in which patients in a general hospital psychiatric clinic improve with therapeutic help from medical students who have limited time and training in psychotherapy. The development of more precise research techniques for investigating psychological data remains an ever present challenge.

Department of Psychiatry

Asphyxia

Since the oxygen requirements of living cells vary with temperature, the rationale for the standard practice of warming asphyxiated infants has been questioned and an extensive series of experiments performed to test the effects of temperature upon asphyxial survival and recovery. These have shown that the shortest survivals occur at the highest temperatures, and the longest survivals at the lowest. In the range between 20°C. and 43.5°C. there is a 50 per cent increase in survival for each 10°C. that the body temperature is reduced. Below 20°C. reduction in body temperature is still more effective in prolonging survival of some animals; others will die at these temperatures because of paralysis of the muscles of respiration and because of other secondary complications which have not yet been analyzed. When these are controlled still lower temperatures may prove desirable in combatting asphyxia. In the safe range, however, animals 10°C. cooler than their littermates will recover completely and spontaneously in every case from exposures which are 100 per cent lethal for control littermates. Cooling has been found to be effective also when

begun after the animals are asphyxiated. Similar results have been obtained with adult animals.

Department of Anatomy

Antigen-Antibody Detection

With a newly developed investigative tool called the fluorescent antibody technique, the sites of formation and the distribution and persistence of antigen as well as of antibody in tissues can be observed by using an ultra-violet light microscope. The method combines the technique of immunology and histopathology. It is applicable to infectious disease in general, as well as to other disorders resulting from antigen-antibody reactions.

Department of Pathology

Differential Counting of I-131 and Cr-51

By using a pulse height analyzer in conjunction with the usual scintillation counting equipment, it is possible to measure separately the concentration of I-131 and Cr-51 in a sample of whole blood containing both radioisotopes, since the different gamma radiation spectra permit the calculation of the contribution of each of the total counts of the mixture. If known amounts of I-131 labelled serum albumin and Cr-51 labelled erythrocytes are injected intravenously, the volume of distribution of each can be determined by counting a single sample of whole blood in a well-type scintillation crystal without separation of plasma and erythrocytes or special counting techniques (absorption by suitable shields, allowance for decay or short-lived isotopes, etc.) which have been employed in previous attempts at the simultaneous measurement of plasma and red cell volumes using radioisotopes. Using the above method, clinical studies of changes in blood volume in congestive heart failure, and in normal subjects after intravenous infusion of dextran, transfusion of whole blood and epinephrine injection have been undertaken.

Department of Medicine

Serum Calcium Determination

Recently work was completed on a micromethod for the determination of serum calcium (J. Biol. Chem., 204, 577, 1953). The calcium is titrated directly with the chelating agent ethylene diamine tetraacetate using ammonium purpurate as the indicator. The end point is determined by means of a spectrophotometer. The titration takes only a few minutes and reliable results are obtained. The possibility of adapting the method for the determination of urinary calcium is being investigated.

Department of Biochemistry

Muscular Weakness

The relationship of loss of strength in the Biceps Femoris and Triceps Surae muscles as a weakness

pattern is being studied by clinical observation and specific muscle testing. These studies strongly suggest that weakness in the Biceps Femoris is of very great prognostic value in determining the possibilities of recovery of the very important Triceps Suræ muscle. Strength in the Biceps Femoris forecasts high probability of recovery in the Triceps Suræ under adequate treatment. Weakness in the combined groups is a sign of poor possibilities for recovery of the Triceps Suræ.

Department of Physical Medicine

Effects of Gravitational Forces on Cell Growth

Experiments on the cells of growing wheat seedlings continuously subjected to forces from 10x gravity to 500x gravity indicate that cell division is progressively inhibited as the force increases. The work required for the tissues to grow against the increased force is compensatory up to about 100x gravity, beyond which force compensation can no longer be maintained. Increased resistance to bending is also found in tissues exposed to the higher forces. These responses precede any cytological changes.

Current work concerns oxygen consumption and a suspected stimulation of cell proliferation at low gravitational forces.

Department of Anatomy

Renal Lymph Flow

Work has just begun on an attempt to measure lymph flow from the renal lymphatics. These vessels offer a third route of exit for materials from the kidney, and, although the route has been and is disregarded in all renal clearance studies, it may be a significant factor. The plan is first to study the anatomy and distribution of the lymphatics in dogs and then attempt to measure lymphatic flow using radioactive isotopes as analytical tools. Except for a very few studies, the renal lymphatics have been neglected experimentally.

Department of Physiology

Dextran

Three separate studies on hydrolyzed dextran were undertaken during the past year. Two involved the species specific edema which dextran produces in albino rats. One was concerned with the overloading of the blood vessels with clinical dextran in dogs.

The conclusions of this work are as follows:

The onset of dextran edema in the rat is constant—being 43 ± 10 minutes after injection.

Dextran edema is accompanied by a decrease in urine formation.

Of a large number of benzoic acid derivatives tested only aspirin and sodium salicylate were effective in preventing dextran edema.

Of a number of diuretics tested only ammonium chloride was active in preventing dextran edema.

Because the general condition of the rat resembles an acute allergic reaction a number of antihistamines were used to alleviate these symptoms. Only Phenindamine (Thephorin®) was effective.

The action of the benzoic acid derivatives was thought to be due to action on the adrenal cortex or the anterior pituitary. But studies on the ascorbic acid level in the adrenal gland showed no change.

It was thought that the particle size of dextran might influence the edema produced. Samples furnished by the National Research Council varying from approximately 10,000 molecular weight to 194,000 molecular weight all showed the same reaction.

As a second research project we have overloaded the vascular system of several animals. We can so far conclude that dextran injected rapidly in large quantity is not excreted rapidly enough to be taken care of normally. The entire vascular system is filled with dextran solution. As a result the number of red blood cells per cc. decreased and the plasma proteins were diluted to the point that coagulation would not occur. Amounts sometimes two to three times the calculated blood volume were given. In most of these animals the venous blood pressure rose to a point at which the pulmonary veins ruptured.

Department of Pharmacology

Urinary Osmolar Concentration and Specific Gravity in Pregnancy

Previous investigators have assumed that a direct linear relationship existed between urinary osmolar concentration (number of particles) and specific gravity; the use of urinary specific gravity as an index of urinary "work" is a time-honored one. Preliminary investigation reveals, however, that particularly at high urinary concentrations there may be no relation between osmolar concentration and specific gravity.

Department of Obstetrics and Gynecology

Intravenous Cholangiography

A clinical investigation is being made on BE-426 (Cholografin) as a combined study between the Departments of Radiology and Surgery.

This product is a contrast medium for intravenous cholecystography and cholangiography.

Most of the studies on this compound have been conducted abroad up to the present date. Our investigation has been conducted with the following scope:

- (1) Immediate toxic reaction.
 - (2) Changes in liver function test following use of BE-426.
 - (3) Demonstration of the anatomy of extra hepatic biliary system (right and left hepatic ducts, gallbladder, cystic duct and common duct and their relationship).
 - (4) Diagnosis of acute cholecystitis.
 - (5) Comparison with oral cholecystography.
- Clinical and radiological data has been completed for a preliminary report.

Departments of Radiology and Surgery

Role of Hormones in Fat Deposition

It has recently been shown that two strains of highly inbred mice which develop spontaneous mammary tumors also become obese by eight months of age when fed a stock ration. On diets containing 50 per cent fat these two strains deposit as much as 46 per cent fat by three months of age. In contrast, two other strains of mice are cancer resistant and show no tendency to obesity under the same dietary conditions. These mice seem to offer an unusual opportunity for the investigation of fat metabolism, since the obesity may be enhanced by dietary means alone and does not require surgical techniques or drugs. It is already known that the muscle glycogen and the running activity of the obese strains are lower than those of the non-obese strains. Thus, muscle glycogen and carcass fat may be used as indices of hormone action. It is hoped to demonstrate some difference in action of various hormones among the different strains by *in vitro* and *in vivo* techniques.

Department of Biochemistry

Experimental Lower Nephron Nephrosis

The purpose of this study is to determine in laboratory animals the effects of ACTH in prevention or amelioration of lower nephron nephrosis. It has been possible to produce this syndrome consistently in rats by the technique of dehydration, hind leg wrapping and myoglobin injection. Preliminary studies indicate that ACTH is not effective in preventing lower nephron nephrosis, and it apparently does not alter the course. Indeed, ACTH alone has been found to produce tubular damage in the rat, although it does not produce renal failure in the dosage used in this experiment.

Department of Medicine

Preeclampsia

The true toxemia of pregnancy remains today one of the leading causes of infant and maternal death in the United States. The paradox of a simultaneously rising venous hematocrit and decreasing urinary output, as the patient with severe preeclampsia progresses (or rather regresses) to eclampsia, remains unanswered. Simultaneous studies of red blood cell volume, "plasma space" and blood protein as correlated with the patient's urinary and clinical findings have not been done. It is hoped that such a study may shed additional light on the cause of the true toxemia of pregnancy.

Department of Obstetrics and Gynecology

Screening of Compounds for the National Heart Institute

Neil Moran, a member of the National Heart Institute, who was stationed at Emory during the past two years undertook the screening of a great variety of plants and chemical compounds for their potential action on the cardiovascular system. Approximately 100 preparations were studied during the past 12 months. A number of interesting substances were uncovered, the most important of which was the isolation from rhododendron of a compound which has most of the actions of the veratrum alkaloids. This material is known as Andromedotoxin and an extensive pharmacological study of the material was carried out. The material is now being tried clinically in patients with hypertension at the Clinical Center in Bethesda.

Department of Pharmacology

Bacteriological Investigations

1. A study of the relations between viruses and leukocytes to determine the influence of the cell on the resistance of the normal and the immune host to virus infection.

2. The study of clotting factors derived from bacteria such as the staphylococcus and the significance of these factors in the coagulation of blood and its disturbances.

3. (In collaboration with the Veterans Administration Hospital and the Organic Chemistry Department of Emory University). A study of fungistatic and tuberculostatic activity of alkylamines.

4. Mechanisms of the conversion of *Coccidiodies immitis* to the tissue phase.

5. A study of the intracellular development of bacteriophage antigens.

6. Carbohydrate metabolism of virus infected tissues.

Department of Bacteriology and Immunology

Reminiscences of an Old Grad . . .



(EDITOR'S NOTE: Robert L. Whipple of Cochran, Georgia, graduated with "first honors" from the old Southern Medical College in the class of 1896. He holds state license number 126. He has practiced continuously in his home town for 58 years. Although an octogenarian, he still carries on an active practice daily. The following reflections on his medical school days were related to the interviewers against a backdrop of an old-fashioned roll top desk stuffed with accumulated papers of the years, recently installed air conditioning and a waiting room full of patients.)

"When I went to Southern Medical College back in 1893, the school was located down on Butler Street in Atlanta, just across from Grady Hospital. The area looked about the same then as it does today, except that the buildings were fewer in number. Most of the students lived near the school; I stayed in a house over on Courtland Street, not far away.

"The course was only two years in duration when I entered, but while I was there, we voted to make it a three year curriculum, and my class—1896—was the first to graduate under the new system.

"The average student back then was a serious minded fellow—I think he was trying to get the most he could from the money his parents spent on him. They were about the same age as medical students these days; there was a scattering of older men just as now—I remember a 45 year old minister in our class who took the full course just for the benefit of the increase in knowledge. Very few of the students were married, and there were

no fraternities. The course consisted mainly of lectures which were held in the arena—the amphitheater—and much of the time both classes met together. Occasionally a teacher would wheel in a patient for demonstration purposes. Occasionally too, the students would be invited over to the hospital across the street to watch one of the surgeons operate. We also attended some of the out-patient clinics of Grady Hospital—surgical, medical, gynecological—these were our main sources of patient contact.

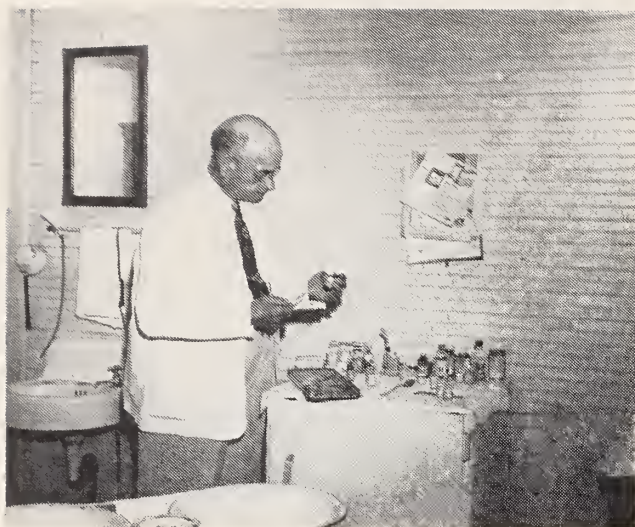
"Our professors were some of the grand old men of Georgia medicine. Dr. W. S. Elkin was Professor of Operative Surgery. Dr. Dunbar Roy was Professor of Medical and Surgical Diseases of the Eye, Ear, and Throat; I never knew why they didn't include the nose—another Professor talked about that. Dr. Roy used to have the students to his office a couple of times a week to review his lectures.

"Then there was Dr. Floyd W. McRae, Professor of Physiology and Lecturer on Medical Literature, and Dr. W. A. Crowe, Professor of Obstetrics and Diseases of Women, and Lecturer on Medical Ethics. You will note the professors doubled on topics back then.

"Dr. H. S. Harris was our Professor of Chemistry; he wore a long frock tail coat, which was always immaculate, and he kept his shoes shined to a high polish. Quite a serious man, but very interesting to study under.

"Incidentally, I remember one of the professors use to tell us: 'If you go in for gall stones, always have some gravel in your pocket to show the family what stones look like'.





"Dr. James B. Baird was Professor of the Principles and Practices of Medicine; of course, Osler's Book was the popular text of the day. Dr. Gaston was our Professor of Surgery, and Dr. William P. Nicolson, Professor of Anatomy.



"One day while we students were with Dr. Nicolson, a mother and child were brought in; the kiddie had swallowed a five dollar gold piece—this was in the days of William Jennings Bryan and the great gold vs. silver arguments. Dr. Nicolson told the mother rather dryly, 'My dear, gold will pass anywhere'.

"Graduation exercises were held in a theatre up on Peachtree Street—the Aragon, I believe. Soon after graduation, most of us took the two day State Board examinations held in the Capitol



building. I passed all right and received my license to practice.

"When one finished medical school in 1896, he usually went right into practice; only two from our class did postgraduate work as interns. and both of these went to Grady. I took a look at several cities—Savannah, Americus—and after some thought, decided to settle in my hometown here. That was 58 years ago, and I have been here since."

Acknowledgments

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Services of the University, for the facts concerning the present physical facilities and future development program of the Medical School; R. E. Whipple of Cochran, Georgia, for his reminiscences of his student days; the Medical School staff members who contributed the scientific articles used in this issue; and lastly the staff of the *Journal of the Medical Association of Georgia*, who guided this lamb through the darkness of the fourth estate.

Ted F. Leigh, M.D.

The Treatment of Congestive Heart Failure

R. BRUCE LOGUE, M.D.

THE PATIENT WITH congestive heart failure has a decreased cardiac output in relation to the metabolic need of the tissues. The output is diminished in relation to the inflow load, and failure may occur in the face of a normal, high, or low cardiac output, as compared to that of the normal person. The inadequate cardiac output is accompanied by a diminished renal blood flow with resultant retention of salt and water, and there may be a redistribution of the intravascular fluid. This, together with venous pressure elevation due to backward failure, is responsible for water-logging of the lungs, liver, and other tissues. In approaching the patient with congestive heart failure, one should always determine: (1) the type of heart disease, (2) the presence of precipitating factors, (3) the presence of aggravating factors or associated disease states and, (4) the nature of any prior treatment.¹ Treatment is directed: (1) to decrease the work of the heart, (2) to increase the force of contraction of the heart, (3) to decrease water-logging and (4) to increase the efficiency of the circulation.

The work of the heart may be decreased by rest, allowing the heart to overcome its oxygen debt and restoring compensation. The avoidance of prolonged or vigorous exercise, tiring shopping trips, prolonged weight bearing and other forms of physical fatigue may be helpful. Rest in the middle of the day may be beneficial. Emotional rest is equally important as the work of the heart may be doubled or trebled under emotional tension. Small doses of sedatives may aid in securing relaxation.

Digitalis remains the primary treatment of the failing heart. It acts by increasing the force of

systolic contraction and by slowing conduction through the AV node. At the present time there are many glycosides of digitalis marketed under a variety of trade names, and while they have the theoretical advantage of (1) assured potency, (2) less irritating properties to the gastro-intestinal tract, and (3) some have more rapid absorption and dissipation, they are no more effective than digitalis leaf. One should become familiar with one rapid acting preparation for parenteral administration and one for oral use. The dosage must be individualized, and the drug given until a therapeutic effect is obtained or mild toxic symptoms occur. The average digitalizing dose for the leaf is 0.1 Gm. per 10 pounds of body weight with a maintenance dose of approximately 0.1 Gm. daily. The initial dose may be 0.4 to 0.8 Gm. with 0.2 - 0.4 Gm. every six hours until the full dose is given. For slow digitalization, one may divide the total amount into three to four doses daily allowing the additional daily doses necessary for maintenance. The average digitalizing dose of digitoxin is 1.2 - 1.6 mg. with a maintenance dose of 0.1 mg. daily. Half of the full dose may be given at one time with 0.2 - 0.4 mg. every six hours until digitalization is completed. The maximum effect of digitoxin occurs in six to eight hours, on the other hand, digoxin acts within three hours and is dissipated within 36 hours. The average digitalizing dose is approximately 2.0 mg. with a maintenance dose of 0.5 mg. As much as 1.0 mg. may be given as the initial dose with 0.5 mgs. every four to six hours until digitalization is complete. For rapid parenteral digitalization, 1.0 mg. may be given intravenously followed by 0.5 mg. every four to six hours. Lanatocid C is particularly useful for rapid action, effects appearing within 15 minutes after intravenous administration.² It is especially beneficial in the treatment

¹ Department of Medicine, Emory University School of Medicine.

² Presented before the Section on General Practice, Medical Association of Georgia, May 1954.

of acute heart failure with pulmonary edema, for the treatment of paroxysmal auricular tachycardia or paroxysmal auricular fibrillation. It will usually cause reversion of the latter rhythms to a sinus mechanism within an hour of administration. It is occasionally helpful, where intractable heart failure exists and one may not be certain whether the patient is fully digitalized, to give small increments such as 0.2 to 0.4 mg. i.v. with a repetition of the dose after two to four hours if necessary. If toxic symptoms occur, the drug is rapidly excreted and the symptoms may be of brief duration. It is always imperative to determine whether digitalis has been administered within two weeks before deciding on dosage, since a single dose of the leaf or digitoxin may produce effects over that period. It should be mentioned that the electrocardiogram does not indicate whether or not digitalis is needed or whether the patient is fully digitalized; in many instances clinical intoxication may be present without any evidence of toxicity in the electrocardiogram. Ventricular extrasystoles are no contraindication to digitalis, and, indeed, they may disappear when the drug is given. On the other hand, the appearance of coupling due to ventricular premature beats in the digitalized patient is a common sign of toxicity and enjoins caution in the further administration of the drug. The presence of myocardial infarction complicated by congestive heart failure is a definite indication for digitalis, but here one should proceed more slowly and err on the side of underdigitalization. Similarly, heart failure due to acute rheumatic fever or other types of acute myocarditis should be treated by digitalis. The response may be less striking than with the more common types of heart disease, and one may need to be content with an arbitrary dose based on the patient's weight, rather than the response of the pulse rate. The same is true with so called "high output failure" due to anemia, cor pulmonale, thyrotoxicosis, beriberi or peripheral A-V fistula. On the other hand, slowing of the heart rate is a rough index of digitalis effect, especially with auricular fibrillation. However, it is important to attain maximum myocardial efficiency, regardless of the heart rate, and in the absence of signs of toxicity, slowing of the heart rate in itself is not an indication for stopping the drug. It is probable that all patients with auricular fibrillation, even with a slow ventricular rate, should be digitalized in order to prevent the abrupt rise in rate which may occur with exercise, emotional stress, anesthesia, etc.

Acute pulmonary edema may be treated by morphine 10-30 mg. or demerol 50 mg. given slowly intravenously. The patient should be placed in Fowler's position and oxygen administered. Tourniquets may be placed on three extremities tightly enough to occlude the venous return, and they should be rotated every 15 minutes. Phlebotomy with the rapid withdrawal of 500 cc. of blood may be equally beneficial. Aminophylline may relieve bronchospasm when 0.25 to 0.5 Gm. is given slowly intravenously. It is useful to combine a mercurial diuretic with the aminophylline. When the patient has not been previously digitalized, digoxin 1.0 mg. or Lanatocid C 0.8 mg. may be given and the 0.5 mg. digoxin or 0.4 mg. Cedilanid repeated in 1-2 hours for two additional doses. One should determine the precipitating cause of pulmonary edema as this may influence subsequent treatment. Such things as myocardial infarction, pulmonary embolism, pulmonary infection, cerebral vascular accident, paroxysmal tachycardia and active rheumatic fever may be responsible.

The most common evidence of digitalis toxicity is anorexia and nausea. Other symptoms such as visual disturbances with greenish or bluish halos, diarrhea, vomiting, abdominal pain or toxic psychosis may occur. It is not widely appreciated that there may be only a single manifestation of toxicity. Furthermore, digitalis intoxication may produce any cardiac arrhythmia—auricular tachycardia, auricular fibrillation, ventricular tachycardia or fibrillation, and it may result in intractable or refractory heart failure.³ The loss of excessive potassium, whether by diarrhea, diabetic acidosis, prolonged vomiting, intubation or repeated mercurial diuretics, may predispose to digitalis intoxication. Those patients who are unable to tolerate the usual digitalis preparations, may be given amorphous gitalin which is marketed under the name Gitaligin. The digitalizing dose is six to seven mg. with a maintenance dose of 0.5 to 1.0 mg. daily. There is a wider range between the therapeutic and toxic doses as compared to other preparations.⁴

When symptoms of congestive failure are not controlled by digitalis, the intake of sodium should be curtailed. When no sodium is added in cooking or at the table, the average intake is about four Gms. To be effective, salt may need to be restricted to one to two Gms., and in severe cases to 200-500 mg. daily. Many patients prefer to receive occasional mercurial diuretics and have a more liberal intake of salt. Mercurials may be ini-

tially given daily or every other day until no further weight loss occurs. Thiomerin has the advantage that it may be given subcutaneously, and one may teach the patient or a member of the family to give it. In the patient with refractory edema, it may help to combine the mercurial with 10 cc. aminophylline and give slowly intravenously. A gain of weight of two to three pounds over a period of a few days may be used as an indication for a mercurial diuretic in the cardiac patient. The presence of albuminuria and elevation of the NPN to 60-80 mg. per cent is no contraindication to their use, and these abnormalities may disappear following diuretics. Rarely, red cells in the urine may occur due to passive congestion, and the only absolute contraindications are acute glomerulonephritis or the lower nephron syndrome. One should suspect electrolyte depletion where there is a failure of expected diuresis, especially when accompanied by weakness, drowsiness, nausea, vomiting and rising NPN. There may be muscle twitching, tremors and dehydration. Hypotension and progressive drowsiness leading to coma may occur.⁵ If the symptoms are mild, a return to a normal or increased intake of salt may be sufficient. However, one must often administer hypertonic saline slowly intravenously. The administration of 200-500 cc. of five per cent saline and combined with restriction of total intake of fluid to 1200 cc. to avoid further dilution of the plasma volume may correct the situation. Electrolyte depletion more commonly involves a lowering of both the concentration of sodium and chloride and often the potassium. Occasionally the chlorides may drop before the sodium and potassium drop, and hypochloremic alkalosis with elevation of the carbon dioxide combining power may occur. This is treated by four to six Gms. of ammonium chloride daily by mouth or 250 cc. of two per cent ammonium chloride intravenously over a period of two hours. Such therapy is contraindicated in the presence of chronic lung disease. Exchange resins or dilute hydrochloric acid by mouth are also useful in the management. Rarely hypochloremic acidosis may occur, particularly in the face of renal disease and ammonium chloride administration. It may be treated by sixth molar lactate or sodium bicarbonate solution intravenously. It is to be recalled that electrolyte depletion may develop in the face of pulmonary congestion and peripheral edema. Electrolyte depletion is especially prone to occur in the presence of renal tubular disease or the so called "salt losing nephritis".

There are several adjuncts useful in increasing sodium excretion. Cation exchange resins may allow a more normal diet, but they are unpalatable and most persons prefer to receive mercurial diuretics or restrict their salt. Enteric coated ammonium chloride in a dose of four to six Gms. daily four days weekly is beneficial. The drug should not be given continuously since acidosis may be produced. Diamox, a sulfonamide derivative, may inhibit carbonic anhydrase formation in the renal tubules and facilitate sodium excretion. It is given in a dose of 375 mg. daily four to five days a week. Rarely, it causes gastrointestinal distress. We have not been impressed with oral mercurial diuretics and have seen severe stomatitis following their use.

The value of physical and emotional rest in allowing improvement of cardiac function to occur is obvious. Rest in the sitting position in a chair may be preferable in the presence of orthopnea since venous return and pulmonary congestion may be less in this position. The use of sedatives may allay anxiety and diminish the burden upon the heart. Opiates or demerol are helpful in the initial stages of treatment, but it should be remembered that they do have some antidiuretic effect and, in addition, may accentuate insomnia by increasing or producing Cheyne-Stokes respiration through the mechanism of diminished ventilation. Aminophylline given by vein or rectally at bedtime may prevent Cheyne-Stokes respiration and diminish cough and wheezing due to bronchospasm. Aminophylline occasionally produces rectal irritation, nausea or vomiting.

The efficiency of the circulation may be increased in a variety of ways. The control of excessive ventricular rates due to ectopic rhythms may effect marked benefit. Where pulmonary embolism is present, the use of anticoagulants may produce striking improvement. The control of pulmonary, urinary tract or other infection may allow compensation to occur. The presence of significant anemia can be treated by red cell transfusion. In patients with chronic lung disease and polycythemia, phlebotomy may be beneficial. The relief of prostatic obstruction, the control of thyrotoxicosis, and the correction of vitamin B deficiency may also produce striking benefit in the cardiac. The removal of significant pleural effusion or ascites may facilitate improvement of cardiac function. Other causes of refractory heart failure are digitalis intoxication, renal disease, hepatic disease, active rheumatic fever, subacute

bacterial endocarditis and hypoproteinemia. Where persistent orthopnea is present, ligation of the inferior vena cava may produce striking improvement. The production of hypothyroidism by radioactive iodine may on occasion lessen the manifestations of congestive heart failure and has been more widely used in patients with coronary disease to reduce anginal pain.

One should not overlook surgically correctible lesions such as patent ductus, coarctation, pulmonary stenosis, mitral stenosis, aortic stenosis, atrial septal defect, pheochromocytoma, Cushing's syndrome, peripheral arteriovenous fistula and constrictive pericarditis. The use of medical and surgical measures for the control of essential hy-

pertension is occasionally rewarded by significant improvement or complete disappearance of congestive heart failure.

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Medical Aspects of Radiological Defense

H. D. BRUNER, M.D.

THE ESSENTIAL problem of the medical profession in radiological defense can be stated in four questions. If there were reasonable answers for these, there would be a basis for proceeding intelligently in the event of a nuclear explosion, but our present information is so inadequate that answers are not in order. One must therefore proceed from a small amount of experimental work and a number of clinical observations not originally intended for that purpose.

The questions are: (1) What does ionizing radiation do in tissue cells? (2) How do the tissue cells react; particularly, what are the reactive processes leading to recovery? (3) What can be done to minimize the effect of radiation either prophylactically or by reversing the intrinsic effect? (4) What can be done to improve the recovery processes, or at least support the general organism while the recovery processes take place?

These four questions are the major concern of the Division of Biology and Medicine of the U. S. Atomic Energy Commission and, undoubtedly, every comparable group all over the world. Prior to 1946 radiation was used chiefly as an experimental tool for it is a convenient experimental means of introducing radiant energy; the formerly sporadic experiments have abruptly expanded into a many-sided concentrated effort.

Theoretical Concept of the Action of Radiant Energy: All studies on radiation must start from the viewpoint that radiation always damages or destroys biological systems; it is *never* beneficial. It has been claimed in the past that small doses of radiation stimulated tissues, and small amounts have been used therapeutically to activate indolent tissues. What actually happened, however, was first destruction followed by repair. The latter

makes itself obvious over a definite period of time whereas the initial destructive phase was instantaneous and not grossly detectable. Reacting-repairing tissues can be observed and assayed in various ways; in some cases systemic responses may be observed.

It has also been pointed out that radiation can and does produce desirable genetic effects, but what is desirable is purely a matter of definition. For example, x-rays were used to create a new strain of *Penicillium notatum* which has an extraordinary penicillin production, but it may be deficient in other respects. One tends to forget the billions and billions of lethal mutants produced along with the one "desirable" mutant. Many agents attack the reproductive elements of cells to produce mutations as well or better than radiation.

The Mechanisms of Action of Radiation: Whenever radiation passes through matter a certain portion of the energy of the ray transfers to the molecules of the substance. One major reaction is that an electron is expelled from its orbit around an atom of a molecule; only rarely is the nucleus disturbed by the familiar types and energies of radiation. On the average, 32 to 35 electron volts are involved at each such ray-electron interaction, but depending on the angle of collision the transfer may be very large, whereupon this secondary electron behaves as an ionizing particle in its own right.¹ The electron knocked free floats about briefly until it settles on a different molecule to create a negatively charged molecule; the molecule from which it originally came is left with a positive charge. A basic effect of radiation, therefore, is to produce such an ion pair and hence the term "ionizing radiation" in connection with the action of radiation on biological material. The electron sometimes is recaptured in which case an ion pair does not occur; the acquired energy must still be dissipated, however.

Professor of Physiology, Emory University School of Medicine.

Read before the Regional Conference on Radiological Defense July 8, 1954.

In addition to ionization there also occurs excitation of orbital electrons, meaning simply that the radiation causes an orbital electron to acquire some five to 12 e.v. of energy which, although insufficient to break apart most molecular bonds, must still be dissipated in the form of heat, light, or special chemical activity.^{2,3} The effects of this excitation process on biological material are almost completely unknown and constitute a blank spot in our knowledge. In terms of total energy transferred excitation probably accounts for 30 per cent and the ionizing process 70 per cent, although excitations are produced two to three times more frequently.¹

In some instances excitational energy may travel over a molecule from the point of incidence to attack a distant weak bond; fracture of the molecule and/or radicle formation results.²

If the molecule is a part of a cell structure such as a chromosome, one of two things happens: (1) An electron is knocked off leaving it charged positively; usually quite rapidly it captures a free electron and returns to its original state. (2) The molecular structure acquires excess energy which is dissipated harmlessly or coincident with alterations of the chemical composition. The long chain molecules of biologic systems, when fragmented, frequently recombine into spectacularly unusual forms. Fractured chromosomes may recombine in functionally meaningless arrangements, and on subsequent cell division the genetic material will distribute into the daughter cells in such manner as to make the cells unfit for their environment.⁴

This concept of the energy being transferred directly onto a stipulated molecule is the "Target Theory" of radiation which has been developed in mathematical form by Douglas Lea.⁵ The theory works rather well when modified by assuming a sensitive volume of transfer considerably larger than the molecular structure itself.

Recent work, on the other hand, has emphasized an indirect or chemical mechanism which recognizes that water is the chief target when solutions (cells) are irradiated. Damage to the water itself is unimportant, but water irradiated in the presence of oxygen gives rise to hydrogen and hydroxyl-free radicals in addition to H_2O_2 and various unusual combinations of H and O.^{6,7} The net effect of these radicals is a highly reactive oxidative medium; they show a preference for carbonyl, sulfhydryl and amine groups, but they will react with any reactive part of any molecule.⁸ In tissues, however, these reactive groups are most

frequently parts of critical proteins such as enzymes, so that when an aqueous solution of tissue components is irradiated, protein molecules and similar compounds are inactivated. The possibility of saturating the body with chemicals whose groupings can compete with the reacting tissue groups for the oxidative free radicals has been thoroughly tested and actually works. An experimental animal which has received a near-toxic dose of glutathione, cysteine or British Anti-Lewisite before exposure can tolerate a distinctly larger dose of radiation; these chemicals have no effect when administered immediately after cessation of exposure.⁹ Such a result might have been predicted from the known very brief existence of free radicals.

In all probability both the direct and indirect mechanisms operate simultaneously and complement each other in damaging the cell; the effects of both are essentially instantaneous. Sometimes one may predominate, as in the case of the alpha particle which leaves a short dense cylinder of energy transfers such as to shatter any biological structure it traverses; beta and gamma rays, on the other hand, probably exert most of their effects by the indirect mechanism since their reactions are diffuse.¹

The Action of Radiation on the Cell: The basic reactions are those described above, but the altered molecules are those which are engaged in the specifically organized processes called *life*. Some molecules are not necessary for life, but others are absolutely necessary. Of the latter some are present in such large numbers that the loss or destruction of a few does not raise any particular problem. Others, however, are present in such small numbers that there are no spares; damage to an appreciable fraction of these criticals can stop the life processes as a whole. Presumably there is an intermediate range where the cell can limp along temporarily while new critical molecules are being built. Special forms are the nucleic acids and the centrosome which contribute little to immediate existence but show the effects of radiation damage when the cell subsequently attempts to undergo mitosis. Lethal radiation damage to a cell is not necessarily accompanied by signs of acute cellular disintegration; the damage may be quite subtle.

Factors Affecting Tissue Damage by Radiation: (1) Locus: Clearly a single burst of energy deposited in exactly the right spot in a cell can exert damage out of proportion to the actual amount of

energy involved. But a slight shift of locus might equally give no discoverable effect. (2) Density of ions: Both gamma and beta rays produce clusters of ion pairs separated by comparatively wide⁴ unaffected intervals, whereas the heavier particles create an almost continuous streak of ionization. In Table 1 is shown the average number of ion pairs produced per linear micron of the path as the particle goes through tissue. It will be noted that the less is the energy of the ray the greater are the number of reactions per unit path length. Also, increased particle mass and charge increases ionization. These figures were computed by dividing the particle's initial energy by 32 e.v. to obtain the average total number of ionizing reactions; this in turn was divided by the mean path length of the particle in microns. Evidently, the greater the density of ionizing reactions in a locus of the cell the greater is the probability of critical damage to the cell as illustrated in Figure I. Such an effect is largely responsible for the differing "relative biological effectiveness" of the various particles. If beta and gamma rays are given a value of one, alpha particles and protons will be roughly 10 times as effective, fission fragments 50 to 250 times, and neutrons with their complex reactions some two to 50 times depending on the energies and test object. (3) Duration of exposure: Briefly put, a greater amount of

energy will be transferred the longer is an exposure to a given flux of radiation and so a greater probability of critical damage. The roentgen to the physicist is a unit of intensity of the beam of radiation, but to the biologist and radiologist it has come to mean a sort of unit of quantity in the sense of a "dose." Although a perversion, it has come about quite naturally from the fact that a definite quantity of energy is transferred when a mass of tissue is exposed to a beam of given intensity for a unit length of time. In this sense the product of intensity times time becomes a quantity which, because the beam penetrates tissue, is essentially the same for each gram of tissue. Thus, the roentgen may mean a unit of beam intensity, an I x T dose to an organ or a region, or an I x T dose to a unit mass (gram) of tissue; generally this must be determined from the context. This situation is most unsatisfactory but until a means is devised to measure the energy transfer, biologists are forced to use the roentgen in a way foreign to its definition.

For many types of responses the product of I x T is a constant so that an increase in one factor can be compensated for by a proportionate decrease of the other. At extremes of duration and time, however, the relationship fails, and it does not hold for every type of radiation.

In a low intensity-long duration exposure it has

TABLE I

The mean linear ion density in tissue produced by different types of incident radiation. Shown are the incident ray or particle, mode of generation or origin, the particle which in some instances secondarily produces the ionization, the mean linear ion density in ions per micron of tissue, and the currently assigned relative biological effectiveness of the initial ray per physical unit of energy. (Adapted from Gray¹).

Initial Ray	Mode of Generation	Secondary Ionizing Particle	Mean Linear Ion Density Ion/ μ tissue	Relative Biological Effectiveness
γ -ray	30 Mev Betatron	Electron	8.5	1
β -ray	Radioactive elements	Electron	\sim 8.5	1
γ -ray	Radium shielded by 0.5 mm Pt	Electron	11	1
x -rays	"Supervoltage" 1000 Kv	Electron	15	1
	"Deep Therapy" 200 Kv	Electron	80	1
	X-ray tubes 30-180 Kv	Electron	100	1
	Characteristic Al K shell (1.5 Kv)	Electron	460	1
Neutrons	Various nuclear reactions with different speed neutrons	Protons	290-1,100	(Neutrons 2-50 (Protons 10
α -rays	Natural and artificial nuclear emissions	α -particles	3,700-9,000	
"Atomic rays"	Fission of Uranium	Fragments and above particles	130,000	50 to 250

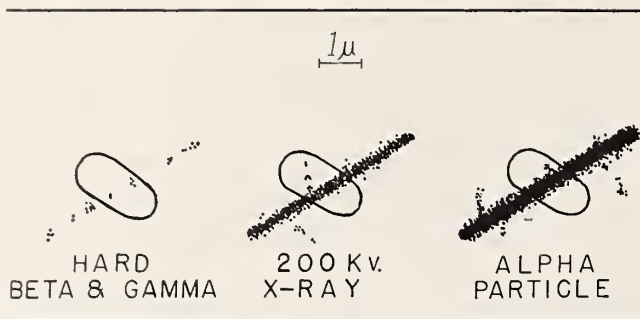


Figure 1

Cloud chamber tracks of various particles superimposed on a single *E. coli* bacterium, modified from Gray.¹ The cloud chamber is designed to induce lateral separation of the ions for visualization; lateral dispersion is actually very much less.

been found that the total cumulative dosage is much larger than that required to produce the same effect using a moderate intensity for a comparatively short time. Evidently living cells possess a recovery factor which operates even while the damaging process is continuing.¹⁰ This idea is made use of therapeutically in fractionating large doses of x-rays. What comprises the recovery factor is unknown, although it is a well recognized phenomenon.

The Action of Radiation on Tissues: A tissue or organ can withstand a much larger dose than the average lethal dose for its single cells. This is an effect of the physiologic reserve of function which may be as much as 500 per cent in some organs. When a tissue is exposed, some of its cells will be so severely damaged as to become non-functional, whereas others are only mildly or negligibly damaged. The latter can maintain at least a minimal functional level enabling the body as a whole to survive while repair goes on. On the other hand, if too large a number of cells are damaged, the organ as a whole may fail; if it happens to be a necessary organ, the body will die regardless of the whole body dosage.

In general, the more rapidly reproducing and shorter-lived are the cells of a tissue, the more prominent are the effects of radiation. Such tissues are said to be "radio-sensitive"; others are relatively radio-resistant.¹¹ At the sensitive end of the spectrum are the cells of the bone marrow which form the circulating blood cells, the lymphoid tissue, the intestinal mucosa and the germinal epithelial layer of the skin. The least sensitive are the cells of the CNS, liver and skeletal muscle; the remaining tissues group midway between. This has a very practical implication: If only a part of the body can be shielded, shield the trunk. But, as is true of thermal burns, the less

the skin area exposed, the greater are the chances of survival. Even though a leg has no critical organs in it, a shielded leg definitely favors survival of animals given whole body radiation except for that limb. Conversely, experiments on animals have shown definitely, as would have been predicted, that any added stress situation such as exercise, fatigue, starvation, thermal burns, fractures, hemorrhage, etc., increases the lethality of a given dose of radiation.⁹

Classification of Radiation Casualties: Since a person at present wears no monitoring equipment for deciding how much radiation he has received, the physician must evaluate the probable radiation dose by the clinical appearance. In some respects a clinical evaluation is superior to dependence on a radiation meter or other type of gadget because the clinical appearance provides an overall estimate of the response to exposure regardless of partial shielding, scattered radiation, or individual sensitivity. Also, it is questionable how reliable a personal metering apparatus would be because a man exposed to radiation would undoubtedly see to it that his meter read enough to get him treatment and shelter regardless of the actual dose. Clinically it is possible to divide casualties into three groups.^{9 10 12}

(1) Survival improbable: Persons exposed to 500 r or more of whole body radiation will show vomiting, lassitude extending to stupor, and will be stretcher cases. The vomiting and physical incapacity appear promptly and progress to death which occurs within three days. The leukocytes show a sharp decline to near zero levels eight to 24 hours after exposure.

(2) Survival questionable: These persons have received 200 to 400 or 500 r whole body radiation and will be chiefly stretcher cases. The majority will vomit on the same day of exposure, but the vomiting will be delayed, not so intense and probably cease after a day or two. The leukocytes will decrease but not as rapidly as in the lethal group. There will be some lassitude and depression, but the victim will rally within three to four days to enter a phase of comparative well-being lasting one to three weeks. During this so-called "latency", there is continued deterioration of the bone marrow, lymphoid tissue and gut which finally shows up as hemorrhages of various types in any location, local and systemic infections with fever, abscesses in the mouth and rectum, vomiting and a bloody diarrhea plus an overall shock-like state. The prognosis depends on how

severe these lesions are and how quickly they appear. If the latent period is short and the vomiting was severe and persistent, the chances of survival are poor. Hair loss begins about the same time as the extreme weakness.

(3) Survival probable: Persons receiving 50 to 250 r will probably be ambulatory unless otherwise injured. Such patients may show mild vomiting on the day of exposure or even later but compared with the others it is negligible. Leukopenia develops more gradually and is less intense. Similarly, there may be no delayed effects but if they do occur they are milder, more easily controlled and the victim recovers sooner.

A dose of 25 r or less of whole body radiation may be tolerated once a week for a few weeks without serious effects if conditions would warrant such an exposure.¹⁰ Certainly a single exposure to 25 r is a good calculated risk; it usually produces no more than a mild leukopenia and gastrointestinal upset.

There are, therefore, two reliable guides to the probable exposure: (1) Vomiting. The sooner and more severely an exposed patient vomits, the more drastic is the patient's reaction and the less the chances of survival. Unfortunately vomiting has a psychologic tinge and like yawning is done sympathetically, so that the physician will have to distinguish the genuine vomiting. (2) Leukopenia. Changes in the leukocyte count are very reliable for the rapidity of development and degree of leukopenia is in direct proportion to the lethality. The total lymphocyte count reacts most briskly, but little added information is to be obtained from a differential count early in the reaction. Because it may not be possible to make leukocyte counts under emergency conditions, vomiting becomes the chief clinical guide.

Treatment of Radiation Sickness: The poor state of the basic information at our command is sufficient reason why there is no specific treatment.⁹ But even if more basic data were available, the multiplicity of lesions, plus infection and fever, plus the shock-like hemodynamics would force the physician to symptomatic and supportive therapy. Thus, if the blood cells drop dangerously low, transfusions are ordered; hemorrhage is an indication for fresh whole blood. Signs of infection call for antibiotics. Electrolyte, water and caloric balances are kept at as nearly normal levels as possible. Above all the patient must be kept comfortable—this depends on good nursing.

A large fraction of exposed patients will also have burns, fractures and lacerations which would ordinarily call for immediate surgical intervention. Under these circumstances, however, the physician will have to decide whether the stress of anesthesia and surgical procedures would be greater than the stress of existing with a simple patch-up until the critical phase of radiation sickness is over. Whether to do anything for the "Survival improbable" group will have to be determined on the spot on a basis of simple logistics.

The prophylactic or protective procedures worked out on experimental animals are too drastic to be extended to man in their present form. Those experiments have served to orient therapy, however, by demonstrating that the damaging effects of radiation take place within the instant of energy transfer and are not reversible in the usual chemical sense.

What Can Be Done Now: Obviously the more effort put into research on this problem the greater are the chances of understanding radiation damage and consequently of developing effective therapy. It is true that radiation affects the intrinsic life processes of the cell, and that rapid progress can hardly be expected, but there will be no progress unless the problem is worked on intensively.

The other effort is to make preparations to use as effectively as possible the techniques and equipment presently at hand. Developing a means of doing this is the problem facing Civil Defense. Plans have been carefully worked out to cope with this immeasurable disaster, but in many respects they seem to be too intricate. They assume the existence of services which are too easily disrupted. For example, what would happen to Atlanta if electric power were off for a week? It might be more to the point to train people how to use an ax, snare chipmunks and dig a latrine.

In the event of a bomb drop, the surviving medical groups will probably treat patients for surgical conditions, burns and radiation sickness with whatever supplies are at hand, under whatever conditions exist. Units should be organized to work autonomously with no man a specialist. If the spread of damage wipes out a metropolitan area, help must come by mobile units from neighboring cities.

In as far as possible, the physician must continue to be a physician; he must enforce public health practices and be prepared to deal with all manner of psychiatric behavior. How he does this

will largely depend on the physician, but it is not out of order to suggest that direct, impersonal violence may be in order. In the chaos that will develop, the physician by reason of his training should be able to judge where the greater good lies.

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Differential Diagnosis of a Case of

Regional Enteritis

WARREN G. SARRELL, M.D., Editor

W. G. Sarrell: The case for discussion this morning is that of a 19 year old college girl who presented the problem of fever, associated with a right lower quadrant mass.

Virginia Grotheer: J. D. (39-529) is a 19 year old college sophomore who began to have intermittent sharp epigastric pain about seven months prior to her admission here on July 9, 1953. The pain would occur any time during the day, but was most frequent at the beginning of a meal and would last about ten minutes with spontaneous regression. She also began to note 4:00 p.m. temperature elevations up to 99.6°F. With restricted activity, she noted a decrease in acuteness of symptoms during the following six months, but a somewhat constant epigastric soreness persisted. Four weeks prior to her admission, she again had sharp epigastric pains with radiation into the right lower quadrant and a marked elevation of her temperature. The following week, she had abdominal surgery with the reported findings of a normal appendix and a firm mass involving about one and one-half inches of distal ileum and one and one-half inches of cecum. Biopsies made from the mass, as well as from one of several mesenteric lymph nodes, were reported as "lymphoid" material. During her recuperative period she felt so well, she announced her engagement to be married, although no date for her wedding was set. But soon the soreness returned and, during the week prior to admission, she spiked a fever of 102°F. She had almost constant nausea and one episode of vomiting. During the whole six months of her illness, there had been no diarrhea, but instead, an increasing constipation without melena or change in the size of her stools. There had been a weight loss of 20 pounds.

Past history revealed a diagnosis of migraine headaches two years prior to admission; there had been no recent symptoms of this however. The patient's brother had a diagnosis of pulmonary tuberculosis in 1940 and was at home for about three months prior to his hospitalization.

Physical examination on admission was normal except for slight evidence of weight loss, mild dehydration and the abdominal findings of a recent, moderately tender, right lower quadrant scar and a palpable, slightly tender, fixed mass of approximately four by five cm. in the region of the cecum. There was no significant adenopathy; peristalsis was normal, and neither the liver nor the spleen was palpable.

Significant laboratory data revealed hemoglobin 12.5 grams per cent, white blood count 10,000 to 13,000 with a normal differential, a normal urinalysis and negative agglutination studies for brucellosis, typhoid O, typhoid H, and proteus OX-19. Stool examinations for parasites, blood, and tubercle bacilli were negative. The second strength tuberculin test (PPD) was positive. Chest x-rays and intravenous pyelograms were normal. Sigmoidoscopy was normal.

On the third hospital day, she developed right lower quadrant peritonitis and spiked a fever to 103°F., which subsided in about 36 hours. On her ninth hospital day, the fever was 102°F., and she had a two-day bout of watery diarrhea. Her temperature at other times was normal except for frequent late afternoon elevations of 99°F. to 100°F. She was placed on 1.5 grams of sulfasuxidine q.i.d. for one week in preparation for surgery on her sixteenth hospital day.

Med Scott Brown: On barium enema examination, the contrast media outlined a normal sigmoid, descending and transverse colon. The cecum was poorly filled. On examination of the small bowel, it was found that

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the terminal ileum appeared to be fixed and coiled about an extrinsic mass. The cecum showed marked irritability and would not fill. These findings were compatible with regional enteritis and ileocecal tuberculosis. Amebiasis and neoplasm could not be excluded. Chest film and intravenous pyelograms were normal. (See Figure A.)

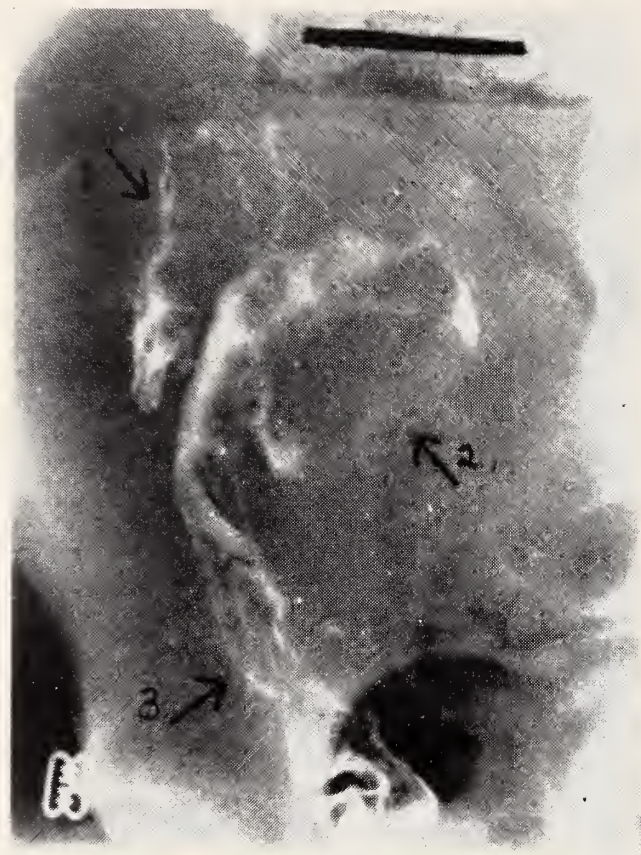


Figure A: (1) Cecum, poorly and irregularly filled with barium sulfate. (2) Distorted segment of terminal ileum. (3) Normal ileum.

Virginia Grotheer: At surgery, there were innumerable adhesions around the cecum and terminal ileum, associated with many firm but not hard mesenteric lymph nodes. Eighteen centimeters of the terminal ileum and the ascending colon were removed, and an end-to-end anastomosis of the ileum to the transverse colon performed. The cut gross specimen showed edema of the mucosa, especially around the valve, and thickening of the intestinal wall. For about 10 centimeters proximal to the ileocecal valve, there were many small scattered distinct ulcers. A larger ulcer with increased induration was seen on the cecal aspect of the ileocecal valve.

The patient's postoperative course was uneventful, and she was discharged afebrile and asymptomatic on August 4, 1953.

Walter Dunbar: This case brings up the differential diagnosis of a small pericecal mass in a 19 year old white female with an eight-month history of intermittent abdominal pain, fever and a 20 pound weight loss. A talc or other *foreign body granuloma* can be ruled out rather rapidly, as the mass was already noted at the time of the first operation, and the biopsy taken at that time failed to verify such a diagnosis. Another unlikely possibility was *periappendiceal abscess*, which would undoubtedly have been recognized on her initial surgery had it been present.

Endometriosis is an unusual cause for a lower abdominal mass. It most frequently involves the sigmoid colon, but occasionally is found at the ileocecal area where it occasionally penetrates the bowel wall and causes gastro-intestinal bleeding.¹ It may, however, give rise to mild obstructive symptoms. Endometriosis usually occurs over the age of 25, and it is associated with dysmenorrhea and pelvic pathology, neither of which our patient had.

Cases of *diverticulosis* and *diverticulitis* have been described in children as young as six years of age,¹ but are rare under the age of 30 and usually are noted over age 50. Only four per cent of cases of diverticulosis involve the ascending colon,¹ and the failure in this patient of barium enema to demonstrate diverticula practically rules out this possibility.

One of the rarer tumors occasionally involving the ileocecal area is the *carcinoid* or *argentaffin* tumor which contains granules that stain brownish-black with ammoniacal silver. Carcinoids most commonly involve the appendix, and do in fact make up roughly 89 per cent of the neoplasms of the appendix,² but they may occur throughout the gastrointestinal tract with the ileum being the next most common site. They are less common than the adenomas of the small intestine, are occasionally annular in their involvement of the terminal ileum and could fit in very well with our operative findings in this patient. These tumors are usually incidental findings at appendectomy or postmortem examination but may give rise to intestinal obstruction or acute appendicitis.

Carcinoma of the colon, the cause of 11 per cent of all cancer deaths, may occur at any age.¹ This patient's tumor, however, involves both terminal ileum and colon, but primarily the former. The biopsy report of "lymphoid" tissue found at the time of her appendectomy helps us to rule out malignancy, but it is entirely possible that the tumor could have been missed.

Carcinoma of the small intestine makes up, according to Ewing, three per cent of the malignant tumors of the gastro-intestinal tract³ and has been reported at age three and one-half,³ but it is rare under age 40. It usually manifests itself by melena or by a mechanical obstruction, such as intussusception. In our case, the patient is much too young, no melena was noted and biopsy failed to reveal carcinoma.

Benign tumors, such as an *adenoma*, *myoma* or *fibroma*, in decreasing order of incidence, most commonly involve the ileum. Occasionally, the adenoma and myoma become malignant (seven and 21 per cent respectively¹), but are quite rare and are intraluminal in 95 per cent of cases. *Pancreatic arrests* are usually found in the duodenum but are rare tumors and infrequently involve the ileum.

Ulcerative colitis, a common disease between ages of 20 and 40, involves the ileum only occasionally according to Bockus.¹ It seems unlikely in this instance in view of the absence of persistent diarrhea, the presence of a mass so early in its course and the absence of demonstrable ulcers by barium enema and sigmoidoscopy. Involvement of the gastro-intestinal tract by sarcoma, which makes up only one to two per cent of intestinal malignancies, has been reported in all age groups with an average age of about 42 years.¹ Less than half of the cases in the small intestine involve the ileum and then manifest themselves by obstruction, occasionally by bleeding and rarely by diarrhea or perforation. As these tumors are usually more rapidly growing than the carcinomas, a palpable mass is noted in about two-thirds of the cases. In our case, *lymphosarcoma*, *Hodgkin's disease* or sarcoma is a definite possibility, but its rarity makes it quite unlikely.

Let us now consider the two most likely diagnoses; namely, ileocecal tuberculosis and regional enteritis. *Ileocecal tuberculosis* may be considered of three types.¹ (1) Ulcerative tuberculosis, by far the most common, is almost invariably secondary to active pulmonary tuberculosis, usually cavitary in type. Including even tuberculosis laryngitis, ileocecal tuberculosis is the most common complication of pulmonary tuberculosis. (2) "Hyperplastic ileocecal tuberculosis," which I believe has frequently been misdiagnosed, is really regional enteritis in most instances. There are only a few cases in which this type of tuberculosis has been proven in the postmortem specimens by culture, by guinea pig inoculation or by demonstration of acid-fast bacilli in tissue sections. Since

Crohn's original article in 1932,⁴ there have been fewer and fewer cases of hyperplastic tuberculosis described, and probably some of them would fit better into the category of regional enteritis. (3) Primary tuberculosis of the ileocecal area is quite rare but has been described by Bockus¹ in several cases. In spite of the familial history of tuberculosis in our patient, the absence of pulmonary tuberculosis and chest symptoms would most likely rule out tuberculosis as the etiological agent. The presence of Stierlin's defect of cecal spasm with barium above in the ascending colon and proximal in the ileum is indicative only of ileocecal irritation.

Our final consideration is that of *regional enteritis*. It is a chronic, non-specific, granulomatous inflammatory process involving most commonly the terminal ileum and manifested by diarrhea, a right lower quadrant mass, fever and later by obstruction, fistulas and abscesses. This entity was first separated from other granulomatous lesions of the intestines by Crohn, Ginzberg and Oppenheimer in 1932,⁴ and, since their initial description, only a few minor concepts of the disease have been added, such as that of skip areas and the occasional involvement of the jejunum, cecum and appendix.¹ It is of interest that about one-third of these patients have had an appendectomy before the diagnosis is established. The average age of the patient is roughly 28 years with most cases falling in the 20 to 50 year age group.

Therapy of regional enteritis is both medical and surgical. In brief, surgery usually resolves itself into either a short-circuiting operation with which the relapse rate varies between 40 and 60 per cent, or resection in which the relapse is 15 to 25 per cent.⁵ The place of cortisone and ACTH is still not completely elucidated, but both seem to give palliative remissions of varying degrees, usually followed by relapses on discontinuance of medication. Some cases, however, obtain no benefit whatsoever. Their use may prove to be advantageous in the preparation for later surgery in the acute or more severe cases.

In spite of the absence of Kantor's string sign on X-ray, the relatively normal colon and the extensive ileal involvement speak strongly for the diagnosis of regional enteritis in our patient. Would Dr. Bauer describe the tissue sections?

Heinz Bauer: The ileocecal valve had the appearance of a reddened and edematous nulliparous cervix, measuring 2.5 cm.

in diameter with a central opening of about three to four mm. In addition to the grossly involved portion of ileum, there was also a two to three cm. cuff of involved cecum surrounding the ileocecal valve. The proximal ileum and distal cecum were grossly, as well as microscopically, free of the inflammatory changes. Histologically, there was acute and chronic inflammation involving the entire bowel wall with extensive fibrosis around the ileocecal valve and for about five cm. of the adjoining ileum. Small ulcerations without distinguishing features were present in the ileum, and a few small granulomatous lesions were seen in the subserosa. Usually, there is more granulomatous reaction in regional enteritis, but otherwise the picture is quite typical.

Max Hall: What is the prognosis?

Walter Dunbar: It is relatively good. She has about a 75 to 85 per cent chance of never having further difficulty.

Daniel Hankey: Perhaps some of you recall that just a few years ago there was a resident here on Ear, Nose and Throat who had fever and an abdominal mass in the region of the cecum. At surgery, regional enteritis was found, but he died postoperatively. He was only 25 years of age.

Henry Jennings: Does ACTH or cortisone acetate benefit these patients, and how much danger would there be from possible perforation if these drugs are used?

Walter Dunbar: Yes, ACTH and cortisone do benefit these patients, especially those with fulminating disease too seriously ill for operation and those considered inoperable because of extensive intestinal involvement. Such patients as these may do quite well on a two to four week course but usually relapse within a few weeks after therapy is discontinued, or rarely a year later, and must be either retreated or tried on maintenance therapy. Some patients do not respond at all and may even progress under apparent clinical improvement. Antibiotic therapy is usually recommended concurrently with hormone therapy as a prophylactic measure. Complications while on ACTH or cortisone do occur, including occasional instances of perforations, abscess formation and drug induced psychosis,⁶ but with the exception of the latter, these may have developed regardless of therapy.

Eugene Ferris: I would like to comment a little more on the course and prognosis of this disease. These patients as a

group resemble ulcerative colitis in that they have somewhat similar psychological problems and the two diseases are sometimes similar clinically. In following some of these patients through the course of several years, their prognosis with respect to cure did not seem so good, and I am surprised that only 15 per cent relapsed. They frequently have bouts of diarrhea and fever when they are emotionally disturbed. They are very dependent on their mothers or some other member of their family and require long and continuous medical follow-up, designed to help them in "growing up" emotionally. This becomes very important in the general treatment, and the final outcome may depend entirely on this. It is of interest that when this patient was presented to us, her mother accompanied her.

Henry Jennings: I have been following this patient, and I am very impressed with her extreme dependence on her mother. Her history indicates that this episode of her illness may well have been related to the engagement ring which she received but did not set a definite date for the wedding. In other words, this would have meant a separation from her mother.

Harvey Hamff: Is there any significance in her history of having had migraine headaches for several years when they stopped some 18 months prior to her admission?

Eugene Ferris: I am unable to say what the underlying factor is in regional enteritis or ulcerative colitis. Their personalities are very similar, except that patients with ulcerative colitis seem much sicker. Emotional stress frequently is a precipitating factor in migraine, and I do not know what significance it has in this case. This patient apparently needs much assistance in order that she may develop a more mature personality.

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A Review and Report of Eight Cases

Strongyloidiasis

FRED N. MITCHELL, M.D.

EVERY PHYSICIAN has at one time or another met with the patient who has had vague abdominal symptoms without symptoms related to other systems. After rather extensive studies many of these patients have been given the diagnosis of "irritable colon syndrome", "hyperactive stomach", "gastroenteritis", "etiology unknown", but more often they are told they are "nervous", "anxious", or other terms in vogue at the particular location. However, it is reasonable to assume that for various reasons ranging from poor diagnostic acuity, through lack of interest in the patient, to laboratory errors, many of these patients have organic disease but are repeatedly misdiagnosed.

There are numerous entities which are vague in their symptoms, rare in occurrence, and require laboratory procedures which are not commonly available, and one cannot censure the practicing physician too harshly for missing some of these diagnoses. On the other hand one must be constantly aware that there are other more common diseases which cause these same vague symptoms and signs but can be diagnosed by the physician's being alert to their presence and using certain laboratory examinations which are readily available to most physicians. In this category falls the disease entity resulting from infection with *Strongyloides stercoralis*—an intestinal parasite of man.

The purpose of the present paper is to recall to the reader some of the factors present in Strongyloidiasis, the difficulties in diagnosis, present methods and limitations of treatment, and to present several cases which have occurred in the city of Atlanta, Georgia.

Review of the Disease

In 1870 Normand²² described a new parasite in several French soldiers from Cochin, China, who were suffering from diarrhea. Subsequently, five of the soldiers died of their disease. There fol-

lowed much enthusiasm concerning the pathogenicity of *Strongyloides stercoralis*, the new intestinal parasite, but later, as the etiology of diarrhea became somewhat clearer, there was a wane in the initial enthusiasm and frank doubt that the parasite was able to cause any symptoms. These feelings were accentuated by a decline in interest concerning intestinal parasites. There was little written about this parasite from the turn of the century until the early 1930's but within the last two decades there has been a return to the early concept of *Strongyloides* as a pathogen with experimental and clinical observations to lend weight to the concept.

The morphology of *Strongyloides stercoralis* has been extensively studied by Kreis¹⁸ and more recently reviewed by Kyle et al.¹⁹ More readily available are the standard textbooks of helminthology and parasitology which adequately cover the morphology and life cycles of the worm.^{2 7 9} It is sufficient to say that the distinguishing morphological features of the rhabditiform larvae are the very short buccal cavity, the doubled bulb esophagus and the genital anlage lying in the mid portion of the body. The filariform larva can be recognized by its notched tail.

The distribution of *Strongyloides stercoralis* is said to be universal paralleling somewhat closely that of hookworm. It is reported by Hinman¹⁴ that the incidence is from one to five per cent in the southern United States while Faust has found an incidence of four per cent in the New Orleans hospital and out patients. Byrd³ has reported an incidence of 0.4 per cent in the indigent patients in the region of Athens, Georgia. However, no good study revealing the true incidence is available. It is interesting that sporadic cases are reported from the northern United States and Canada in persons who supposedly have never left those environs.

In order to understand some of the manifestations of infection with this parasite it is necessary to have in mind the varied life cycle.

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CHART I

Life Cycle of *Strongyloides stercoralis*

A. Exogenous Methods

1. Free living cycle in which excreted rhabditiform larvae or the offspring develop into infective filariform larvae or into another free living generation outside the host.
2. The direct cycle in which excreted rhabditiform larvae mature into filariform larvae which are immediately infective.

B. Endogenous Methods

1. Autoinfection of Faust by which the rhabditiform larvae develop into infective forms in the lower intestine and penetrate the perianal skin when excreted.
2. Hyperinfection of Faust in which maturation into filariform larvae occurs high in the bowel and the infective larvae penetrate the mucosa and migrate via the venous system through the lungs, are eventually coughed up and swallowed and then mature in the upper intestine.
3. Extraintestinal cycle in which the parasites become lodged in the pulmonary tree during their migration and then undergo maturation and complete their life span within the lung tissue.

It is felt that the host may be infected by either ingestion or penetration of the skin by the infective form. After skin penetration the migration through the body is much like that of *Ascaris*.

In spite of the varied life cycle, *Strongyloides* is at certain disadvantages in the parasitic world for, unlike most Nematodes, it is unable to undergo encystment and is exceptionally sensitive to physical changes. Kreis¹⁸ reports that this genus of Nematodes is unable to survive over seven days in experimentally inoculated soil and that refrigeration was uniformly fatal to the larvae. Cordi and Otto⁶ were able to show that the optimal temperature for development was in the range of 23 to 30 degrees centigrade while temperatures in excess of 43 degrees centigrade and temperatures between zero and eight degrees were incompatible with continuation of the life cycle. In addition they showed that between the temperatures of 15 and 16 degrees the life cycle was markedly inhibited.

The pathology of Strongyloidiasis has been extensively reviewed by Kyle et al.,¹⁹ and it is sufficient to say that the primary site of infection is in the upper gastrointestinal tract especially the duodenum and upper jejunum. In addition there is autopsy or laboratory evidence of parasites in the lower jejunum, ileum, colon, liver, gallbladder, mesenteric lymph nodes, stomach myocardium, pericardial fluid, urinary tract and pulmonary systems. Although there is still argument concerning the exact nature of tissue reaction, pathologists are in agreement that *Strongyloides* does cause pathological changes in the infected tissue which

are sufficient to result in clinical signs and symptoms.

As has been pointed out, there has been considerable discussion as to the pathogenicity of *Strongyloides*. However, through the years several fatal cases have been reported.^{12 13 14 16 17 19 24 25} In addition one must call attention to Jones' series¹⁶ in which six cholecystectomies and 24 appendectomies were performed in 100 patients without relief of symptoms before the diagnosis of Strongyloidiasis was made. The major signs and symptoms are best reviewed under systems affected.

Skin

During the invasion of the skin by the filariform larvae there is an accompanying pruritus which is similar to the "ground itch" of hookworm disease. However this history is often lacking. Also related to the skin is the presence, in many cases, of an urticarial rash which is said to be most common on the inner aspects of the thighs. This skin reaction is an inconstant finding but was present in 14 per cent of Jones' cases. Chadham⁴ felt that the urticaria coincided with the hyperinfection, especially when generalized. One may then postulate an allergic phenomenon to be operating during certain phases of infection, especially during initial infection or certain hyperinfection cases. Other skin lesions have not been attributed to *Strongyloides*.

Lungs

The pulmonary symptoms, when present, make their appearance some 24 to 48 hours following the penetration of the skin by the filariform larvae. In hyperinfection the pulmonary symptoms and signs have no definite time of occurrence. Those symptoms attributed to the parasite have been cough, mild upper respiratory infection, hemoptysis (especially with hyperinfection) and dyspnea. A number of workers,^{1 4 8 9 10 20} have called attention to the pulmonary symptoms of this disease. Lowe and Lancaster have reported a high incidence of pulmonary symptoms while Hinman has not been impressed by lung involvement.

Gastrointestinal Tract

The most impressive array of symptoms attributed to *Strongyloides* have been related to the intestinal tract. The most common single symptom has been found to be abdominal pain. It has been variously described as dull, aching or cramping in nature and is seldom referred to as a sharp or stabbing pain. Radiation of the pain is infrequent. King¹⁷ has reported the pain to be epigastric in 14 per cent of his cases while 57 per cent have had

lower abdominal pain. On the other hand Jones found that in 45 per cent of 79 cases complaining of abdominal pain it was located in the epigastrium; while six per cent localized their pain in the lower abdomen and the rest in various abdominal regions. Right upper quadrant pain has been the most common location described but no area is specific.

Belching has been listed as another common symptom^{15 16 17} but is not a common presenting complaint. Flatus is sometimes annoying. Diarrhea is also found in a large number of cases during some period of the disease,^{16 17} but constipation or changing bowel habits may be of prime importance according to King.¹⁷ In a fair number of cases nausea and vomiting have been rather annoying symptoms.

A large number of symptoms have been found to be associated with *Strongyloides*. These symptoms include anorexia, pyrosis, weakness, fatigue, vertigo, palpitations, syncope, invalidism, psychoneurotic reactions, headaches, weight loss, progressive weakness, abdominal distension, presence of other parasites, foreign residence and the exaggeration of the abdominal pain some 15 minutes after meals. The most common food offenders are fats, fibrous foods, highly seasoned meals and alcohol. In addition to these findings sloughing of the intestinal mucosa and ascites have been reported,¹³ and one case of jaundice²¹ has resulted from *Strongyloides*.

Laboratory

Although the clinical findings are important in maintaining a high index of suspicion there are certain highly suggestive and two diagnostic laboratory findings. Eosinophilia has been present in many of the affected patients but has been absent in the presence of rather severe infections. King¹⁷ reported eosinophilia in 71 per cent of his cases while Jones¹⁶ stated the average eosinophilia to be nine per cent in his series. Hinman¹⁵ found an average eosinophilia of eight to 11 per cent of his series. Faust⁹ says that in the early stages of the infection one may find an eosinophilia of 25 to 30 per cent with an occasional case with 75 per cent eosinophiles. He found that in general chronic cases the eosinophiles usually are in the range of six to eight per cent. Although eosinophilia may turn one's attention to the possibility of infection and examination of the stool, the absence of eosinophilia does not negate the possibility of infection. In addition, because of the inconsistencies in range, the eosinophile count cannot be used as an index in the evaluation of treatment progress.

Hypochlorhydria has been reported as a common finding,¹⁸ but Hinman¹⁵ was not impressed with gastric analysis in his series. Anemia has not been a striking feature of this disease according to most workers and when present is not striking. Occult blood has not been found to be excessive according to King¹⁷ while Chadham, in his case, reported anemia without cause other than *Strongyloides*. Many workers have reported leucocytosis as a finding in the early phases of the disease.^{9 13 14 17}

Roentgen examination has been of some value in the diagnosis of this disease. Examination of the gastrointestinal tract may reveal irritability of the colon and deformity of the duodenum similar to duodenitis.^{1 16} Desportes,⁸ after infecting himself with the parasites, was able to demonstrate a swollen duodenal mucosa. Examination of the chest has been found to simulate primary atypical pneumonia, pulmonary tuberculosis or may cause other confusing transient localized infiltrations. Other changes have not been described.

Finally the demonstration of the characteristic rhabditiform larvae in the stools or duodenal washings is the only diagnostic procedure available. Jones¹⁶ was able to demonstrate the larvae in only 80 per cent of his cases while 91 per cent of the duodenal washings performed were positive. Other workers have pointed out the benefits of stool examination in the diagnosis of this disease and have emphasized its importance as a diagnostic tool.^{15 17} Diagnosis by duodenal or stool examination are fraught with pitfalls which must be realized. First it should be pointed out that *Strongyloides* ova are found in the stools only after severe purging or during severe diarrhea, and when present are extremely difficult to differentiate from the ova of hookworm. In addition one must realize that the female parasite is capable of producing about 50 ova a day, and consequently they will not be easily demonstrable when present; for the same reason the rhabditiform larvae are often scant in number. The method used in the examination of the stool is also important. Direct smear is often of no value in demonstrating the larvae, and because the larvae do not float in brine other means of floating the larvae must be used. In view of the difficulty with brine and glucose, the zinc sulfate floatation has been found to be the method of choice for demonstrating the larvae. Another procedure of some value is to fill a depression in the specimen with water and incubate 24 hours and examine the liquid by direct smear or floatation. In addition, if the diagnosis is strongly suspected and duodenal

and stool examinations have been negative, one may incubate a specimen of feces after the method of Lowe and Lancaster.²⁰

Diagnosis

The diagnosis is to be suspected in any patient who has abdominal pain which cannot be explained on other grounds. In addition to abdominal pain any of the above described pulmonary or skin findings without other demonstrable cause should call attention to parasitism. The finding of eosinophilia without other allergic manifestations is sometime helpful in making the diagnosis, and unexplained urticaria may be sufficient cause to investigate the stools for parasites. At any rate it must be borne in mind that negative stools on one or two occasions do not rule out the condition and absence of eosinophilia is of no importance. One should be certain that adequate stool examination by the zinc floatation method or stool culture is carried out before the diagnosis is discarded.

Treatment

At the present time there is no good treatment for *Strongyloides*. Many medicines have been advocated but have been found wanting. Chesterman⁵ has reviewed the treatment of *Strongyloides* infection but was unable to add anything new to the armamentarium of drugs which are currently used. However, he has pointed out that many drugs have been proven useless. The list includes santonin, hexylresorcinol, thymol, tetrachlorethylene, mepaerine, tartar emetic, sodium antimony tartrate, organic antimonials, emetine, niloden and letrazan. The only drug which shows any action is gentian violet. Good therapeutic results in this country were first demonstrated by Faust. The present recommended dose for adults is one grain (65 milligrams) three times daily after meals for a period of 17 to 21 days. One and one-half hour enteric coated tablets are to be used. Children require one gram of the drug per kilogram of body weight given in divided doses twice daily. One may use the instillation of 25 cc. of a one per cent solution directly into the duodenum every other day for five treatments or 25 cc. of a one-half per cent solution may be given slowly intravenously every other day for five injections in the case of parenteral infections. Nausea and vomiting when they occur are contra-indications to further duodenal, or intravenous dosage and indicate that the oral dose should be reduced slightly.

In order that the patient be termed cured, it is necessary that the stools be examined at weekly intervals following treatment. They should remain

negative for one month and periodic examinations should be made throughout the following year. The eosinophile count, as already mentioned, should not be used as an index of treatment evaluation since it is markedly influenced by infection, allergy, and other factors.

CASE REPORTS

Case One

B. J. was a 10-year-old white school boy who was referred to the DeKalb County Health Department Clinic because of abdominal pain in school. He complained of left upper quadrant pain for two weeks' duration and anorexia for one week. One week prior to his initial visit he had a "splotchy" erythematous rash on the inner aspect of the left thigh. Following the initial visit the patient developed a brief upper respiratory infection, and he stated that he had as many as four stools daily. He complained of no other symptoms. The physical examination revealed only upper left quadrant abdominal tenderness and slight hyperpigmentation over the medial aspect of the left thigh. His smear differential and leukocyte count which were not available on the first visit showed a white count of 14,700 and 28 per cent eosinophiles; with this information three stools were sent to the State Laboratory and were reported negative for ova and parasites. However, the zinc sulfate floatation method of examination was not used. Subsequently, after the eosinophile count increased to 55 per cent, a single stool examination by the zinc sulfate method revealed the rhabditiform larvae characteristic of *Strongyloides stercoralis*.

Other examinations including chest x-rays, liver function studies were negative. Duodenal washings and gastric analysis were not performed. Treatment has been difficult because of the hesitancy of the patient to take the medication and on the last examination his stools still showed *Strongyloides stercoralis*.

Case Two

A 35 year old housewife was first seen in the clinic of Grady Memorial Hospital in January 1950 for right upper quadrant pain. A routine stool examination showed larvae which were thought to be those of *Strongyloides stercoralis*, while differential smear showed a five per cent eosinophilia. She was not seen again until October 1951 when she returned with acute right upper quadrant abdominal pain and was diagnosed as having acute cholecystitis. On a second visit two days later the diagnosis of Strongyloidiasis was suggested in addition to gallbladder disease, and she was hospitalized. During her hospitalization only one of nine stools examined revealed the larvae of *Strongyloides*. Blood studies revealed leukocyte counts ranging from 14,300 to 9,200 and differential smears showed eosinophilia from 18 per cent on admission to three per cent on discharge. Two gallbladder series and one upper GI series were reported normal. During her hospitalization she was reported by one observer to "belch with great gusto" at intervals of two to three minutes. She was treated with gentian violet, 65 milligrams four times daily for 21 days. Nausea persisted throughout the treatment and continued for three days following termination of treatment. Follow-up studies were not available.

Case Three

A 32 year old housewife was admitted to Emory University Hospital in 1932 because of rectal bleeding and tarry stools for a duration of 10 days prior to admission. Review of systems revealed anorexia, upper left abdominal pain without relation to food or relief of pain with anacids, constipation and "considerable gas." Routine blood work revealed a leukocyte count of 9,150 with 17 per cent eosinophiles on differential. Gastric analysis showed 84 degrees total acidity with 44 degrees of free hydrochloric acid. Barium enema showed extensive colitis of the descending colon while proctoscopic examination was reported as normal. Stool examination revealed many larvae of *Strongyloides* and a negative guaiac. She was treated with gentian violet, 10 milligrams three times daily for eleven days, and discharged to be followed on the outside. Follow-up was not available.

Case Four

Mr. F. W. L. is a 45 year old white male who was referred to the Emory University Private Diagnostic Clinic because "he had always had a weak stomach." The condition had grown worse since 1947 and had been complicated by persistent diarrhea and giddiness. Elsewhere "amoeba cysts" were identified on three occasions, and the patient was subsequently treated with three courses of carbasone without relief of his symptoms. The patient complained of gas for many years, intolerance to highly seasoned foods, pork, cane syrup, certain fish which caused urticaria, and a "crowding sensation" in his stomach which "built up." He had been previously diagnosed as having gallstones, possible prolapse of the gastric mucosa and hyperactive stomach.

The physical examination revealed a moderately tender liver which was palpated one centimeter below the right costal margin on deep inspiration but was otherwise negative. The laboratory studies revealed a trace of albumin in the urine, normal liver function studies and normal sedimentation rate, hemoglobin and leukocyte count. The differential smear revealed eight per cent eosinophiles. Upper gastrointestinal series showed active peristalsis and minimal prolapse of the antral mucosa with delay in the opening of the pylorus. The barium enema demonstrated multiple small diverticula without signs of irritability of the colon. Gallbladder series was normal. Stool examinations were done, the first being reported as negative but the second showing typical rhabditiform larvae of *Strongyloides stercoralis*. He was treated with gentian violet, 65 milligrams three times daily for 14 days, but the patient failed to return for follow-up visit.

Case Five

A three year old male was seen at Grady Memorial Hospital because of failure of treatment of *Necator americanus* infection. The symptoms complained of were cramping abdominal pain, diarrhea of one to two stools daily and increasing paleness. On admission he was found to have 3.28 million red blood cells and a leukocytosis of 15,200 with 14 per cent eosinophiles on differential smear. The admission stool showed only *Necator americanus*, but later stools examined in the State Laboratory reported the presence of *Necator americanus* ova, larvae of *Strongyloides stercoralis* and *Giardia lamblia*. He was treated with tetrachlorethylene for the *Necator* infection and given two courses of gentian violet, 3/20 grain enteric coated tablets twice daily for eight days, and he had one duodenal instillation of 10 cc. of a one per cent solution of gentian violet. During the hospitalization the leukocyte count ranged from 4,200 to 10,600 while showing from 31 to four per cent eosinophilia. Eight members of the patient's family were found to have hookworm infection and were treated accordingly. Recently the patient was re-examined and found again to have hookworm and *Strongyloides*. He is in the process of treatment for both parasites. The public health department is investigating the family.

Case Six

The sixth case is that of a middle aged white male who had been diagnosed as having chronic lung disease, portal cirrhosis and duodenal ulcer. For the latter he had had a subtotal gastrectomy performed.

He was re-admitted to Grady Memorial Hospital in 1951 because of "pain persisting in the abdomen." The systems review revealed diffuse wheals associated with recurrent diarrhea—the latter persisting during his hospitalization. The leukocyte count ranged from four to seven thousand with eosinophilia from seven to 16 per cent. On four occasions the rhabditiform larvae of *Strongyloides stercoralis* were found in his stools. During the hospitalization the urticarial rash and diarrhea continued while he continued to complain of abdominal pain unlike that which he experienced with his duodenal ulcer, and upon questioning only vague description could be obtained. The pain was not relieved by alkalis and was often increased by eating. He was treated with two courses of gentian violet in adequate dosage.

Following discharge he was seen frequently, but there is no record of stool follow-up. However, in February of 1953 he was found to have *Ascaris lumbricoides*, but no other

parasite was reported. Several records show persistence of the vague abdominal pain, diarrhea and the urticaria which puzzled the housestaff. He was treated in the hospital on several occasions for melena and other unrelated complaints.

Case Seven

Mrs. L. W. is a middle aged white woman who was admitted to Grady Memorial Hospital with rather advanced anemia and congestive heart failure. She was found to have a four plus guaiac, and subsequently it was discovered that she had a severe hookworm infection. There was no eosinophilia during her hospitalization. The first examination of her stool revealed larvae which were thought to be *Strongyloides stercoralis*, but subsequent examination were less convincing in face of constipation in the patient; the diagnosis was discarded except by the interne on the ward. The patient was transfused with seven pints of blood and given two courses of hexylresorcinol for the hookworm, but after treatment the ova of hookworm were still present. Following the hookworm treatment the larvae of *Strongyloides* were demonstrated by zinc floatation method while the larvae of hookworm were seen also. The presence of the *Strongyloides* was confirmed by stool culture with the demonstration of the notched tail filariform larvae and free living forms. Duodenal washings were unsuccessful but the patient received 20 cc. of a one per cent solution of gentian violet through the Levine tube and was started on 65 milligrams of enteric gentian violet four times daily with increasing doses up to tolerance. She was discharged during treatment and follow-up is not available.

Case Eight

V. E. P., a 54 year old physician, was admitted to Emory University Hospital for treatment of *Strongyloidiasis*. He reported that in February 1953, while on a trip to Mexico, he developed diarrhea, nausea, vomiting and dehydration which cleared up after two or three days. However, following this episode he never felt quite the same as before, being troubled by a tendency toward diarrhea of two to three stools daily, fatigue and vague epigastric pains. After several months he discovered *Strongyloides stercoralis* to be present in his stools in large numbers. Following the discovery he treated himself with maximum dosage of gentian violet on two occasions, but each time he had a recurrence of the infection and symptoms.

The past history is significant in that the patient was a member of the Army Medical Corps during World War II and served in the Pacific. While on several assignments he felt that the sanitation left much to be desired and that infection could have occurred during that period. In 1947 the patient was treated at Emory for an upper respiratory infection characterized by cough, fever up to 102 degrees over a three day period and malaise. The X-rays at that time showed areas of density in the region of the right hilus which had the appearance of pneumonitis. The hemogram showed leucosinophiles. It is possible that the patient had a *Strongyloides* induced pneumonitis, but such cannot be proved. The family history and review of systems were non contributory.

Except for a palpable liver edge of one centimeter the physical examination was normal. Laboratory procedures revealed a hemoglobin of 15.2 gm. per cent, sedimentation rate (Westergren) 15 mm/hr., 9,600 leukocytes with 41 segmented forms, 51 lymphocytes, three monocytes, and five eosinophiles. The total eosinophile count was 1,331 per cubic millimeter. B.S.P. was normal. A stool examination done at the office just prior to admission was reported to have many rhabditiform larvae of *Strongyloides stercoralis*. The stool was examined by a qualified technician who had special training in parasitology. One stool examined by the author after the institution of therapy revealed one larva.

The patient's treatment consisted of seven intravenous injections of 20 cc. of 0.5 per cent gentian violet; every other day 25 cc. of 1.0 per cent gentian violet were introduced into the duodenum. This course of therapy lasted eight days. Unfortunately severe sclerosis of the veins prevented continuing the intravenous therapy; such complications have not been encountered anywhere in the literature. It was found that the patient tolerated the duodenal intubation much better if Pro-

banthine® and phenobarbital in combination were given the night before and on the morning of intubation.

Following discharge the stools were negative at the end of one and a half and two and a half months. Both stool cultures and zinc floatations were performed. However, about two months following therapy the patient began to develop mesial thigh and buttock urticaria. In the three months following therapy, four stools have been negative.

REVIEW OF SIGNS AND SYMPTOMS IN EIGHT CASES*

Abdominal pain	7
Upper	5
Lower	0
General	1
Other diseases causing	
abdominal pain	2 and 1?
Gas or belching	2
Diarrhea prior to treatment	3
Unexplained urticaria	3
Leukocytosis	2
Eosinophilia	6
Range	0 to 55%
Average	15.8%
Pulmonary symptoms	2?
Positive stools	8
Other parasites	2

Discussion

The above chart of signs and symptoms found in the eight cases presented substantiate the finding in the past. Almost all of the findings described in the past can be found in these eight cases, but because of co-existing parasites or other pathology one cannot assign direct cause of all of the symptoms to *Strongyloides stercoralis*. It is also evident that most of the symptoms are not characteristic of any definite pathology and could easily be passed off as simply indigestion, irritable stomach or anxiety in the presence of the usual roentgen examinations. It was most fortunate that in six of the eight patients a significant eosinophilia was present and directed attention to the possibility of parasitism. It is also important that the single patient who showed no eosinophilia suffered from an overwhelming parasitic infection, both from *Necator* and *Strongyloides*, which was nearly fatal.

Further examination of these cases also shows the importance of careful and persistent stool examination. Case One gives evidence of the ineffectiveness of the brine floatation method for demonstrating the larvae while glucose floatation on stools known to contain rhabditiform larvae

were equally ineffective. The zinc floatation procedure was effective in all cases although stool culture was resorted to in Case Seven in order that there be no possible confusion with the larvae of *Necator americanus* which were present in abundance.

One more feature which is important is the failure to follow the stools in evaluating treatment. A single course of gentian violet, even in adequate dosage, is not effective in curing all patients and several courses of treatment may be necessary (Case Eight). Failure to realize this may lead to danger to the patient and failure to eliminate the cause of distress so that the pathogenicity of the parasite is doubted. Also it may be pointed out that the physicians were as negligent in performing follow-up stool examinations as the patients were negligent in returning for follow-up. In some patients this failure to return may be the result of failure to eliminate the symptoms with a single course of therapy and resulting loss of confidence in the physician. Warning that cure may require several courses of treatment can avoid this unhappy outcome.

In collecting these eight cases, five of seven Atlanta general hospitals were polled. These cases represent the total number of coded cases obtained since the institution of the coding system.

Emory University Hospital	3
Grady Memorial Hospital*	4
DeKalb County Clinic	1
Crawford W. Long Hospital	0
Piedmont Hospital	0
Georgia Baptist Hospital	0

Because of the reported incidence of five per cent in certain areas of the South, it would appear that this small number of cases over a long period of years represents low index of suspicion or inadequate stool examination. True, many cases are diagnosed in the office and treated as outpatients, but the above cases are far below the hospital incidence of five per cent reported by Faust in New Orleans and is also below the incidence reported by Byrd in a neighboring Georgia city. The only way in which this discrepancy can be overcome is by constant awareness of the clinical picture and careful stool examination.

In three patients now undergoing treatment for their infection, gentian violet in dosage up to individual tolerance is being employed. To date the results of this treatment are encouraging, but follow-up examinations are not complete. It is

* Does not include fatal case in a chimpanzee proven at autopsy at Grady Memorial Hospital.

hoped that higher dosage may result in higher cure rate. Even when cure is not obtained with vigorous treatment repeated courses with gentian violet will prevent the hyperinfection phase of the life cycle from developing. Since this phase of the life cycle results in the most serious complications, prevention of its occurrence is most desirable, and the patient should be followed and treated for years if necessary.

Case Eight brings to light a heretofore unpublicized point. The sclerosing of veins during intravenous therapy was most disturbing and prevented the completion of anticipated therapy. The cause was not demonstrated to be in the method of solution preparation. In addition, some help was obtained in making duodenal intubation less traumatic in that nausea and vomiting were prevented. Newer drugs, namely Thorazine, may be even more helpful.

Summary

- 1. The clinical picture, laboratory findings, diagnosis and treatment of Strongyloidiasis is reviewed.
- 2. Eight cases of Strongyloidiasis from the Atlanta, Georgia, hospitals are reported.
- 3. Reemphasis is placed on the pathogenicity of *Strongyloides stercoralis*, and the need for vigorous treatment and long term follow-up is advocated.

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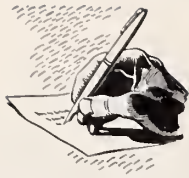
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Correction

A chart in the article "Treatment of Erythroblastosis Fetalis" by H. Luten Teate, Jr., M.D., was published incorrectly in the August issue of the Journal. The chart, Table V on page 701, should have read as follows:

Table V—Effect of Replacement Transfusion on Mortality Rate and Occurrence of Kernicterus

Treatment	No. Cases		Deaths		Kernicterus	
	No.	%	No.	%	No.	%
No R. T.	86		25	29.0	8	9.3
R. T. before 8 hrs.	93		5	5.3	0	0.0
R. T. after 8 hrs.	35		2	5.6	5	14.2



abstracts by georgia authors

Arnold, Edwin T. Jr.; 20 Commerce St.; Hogansville, Ga. "The Patient Teaches the Doctor," Medical Times 82:404-407 (June) 1954.

This paper is built upon the history, physical examination and, in general, close acquaintance with one patient who is typical of a very large segment of the people we see in everyday practice.

She is a person of above average intelligence, as so many of these people are, but who cannot handle her life situations.

She realizes her problem and points out to the author the futility of having physician and others dwell upon the fact that the trouble is neurosis and expecting this to remedy the situation. She emphasizes the need of something of a definitely constructive nature by all of us who have to do with the therapy of such cases. She states that the emphasis in modern life is to build to higher peaks of excitement in all fields such as literature and entertainment and that so little is done to create a salubrious environment for people like her.

The conclusion reached by the author is that the greatest help for these people is within the spiritual realm, and that we physicians need to grow deeper spiritually ourselves in order that we may be of greatest help to our patients.

Phillips, Hayward S.; 1082 Bertram Rd.; Augusta, Ga. "Physiologic Changes Noted with the Use of Succinylcholine Chloride as a Muscle Relaxant During Endotracheal Intubation," Current Researches in Anesth. & Analg. 33:165-177 (May-June) 1954.

Succinylcholine, Anectine, an ultra short-acting muscle relaxing drug, was used for endotracheal intubation and as a continuous drip for muscle relaxation in laparotomies.

The drug was administered by three different procedures for intubation; first anectine was given before the anesthetic drug surital sodium, second anectine was given following the surital sodium, and third anectine was given following the surital sodium and oxygen was administered to prevent hypoxia and hypercapnia. Electrocardiographic tracings were made before and during the administration of the drug; the blood pressure, pulse rate and respiration were recorded during each procedure.

Succinylcholine was also administered by a continuous drip for intubation and continuous muscle relaxation in laparotomy.

There were certain physiologic changes noted as follows: 1. Muscle fasciculations. 2. Apnea. 3. Elevated blood pressure. 4. Cardiac irregularities as shown on the electrocardiographic tracings including auricular standstill, nodal rhythm and ventricular extrasystole. 5. Bradycardia followed by tachycardia.

It is advisable to be cautious when using succinylcholine, with those who have any disturbance of the conductive mechanism of the heart and also patients who are in the upper age groups, particularly if they have hypertension.

Most of the physiologic changes noted can be avoided if succinylcholine is administered following a barbiturate as the anesthetic agent, or if the drug is administered slowly.

Finkle, Alex L.; Scardino, Peter L.; Prince, Charles L., 2515 Habersham St., Savannah, Ga. "Surgical Treatment of Genital Elephantiasis," AMA Archives of Surg. 68:713-719 (May) 1954.

A brief summary of the differentiation between elephantiasis nostra and elephantiasis arabum is presented in connection with a case report of huge scrotal elephantiasis secondary to lymphopathia venereum and granuloma inguinale complicated by squamous carcinomatous degeneration at the left scrotoperineal junction in a 41 year old negro. The patient was seen 16 years after his initial venereal infections, during which long period antimonial and antibiotic therapy had failed to arrest the progression of the disease.

Of note as a physical finding was a tremendously enlarged scrotum, with the urethral meatus located 35 cm. distal to the bladder neck. There was a necrotic lesion at the left scroto-inguinal junction, extending almost to the anus posteriorly.

Surgical therapy was performed in two stages. The first consisted of excision of the 26 pound scrotal mass, a cicatrized right inguinal node and the necrotic lesion. The testes were preserved, as was a five inch segment of penis; the latter was buried subcutaneously in a suprapubic position. One month later the penis was uncovered and a split thickness skin graft was placed around it. The testes were implanted subcutaneously in the groins. No dressings were used against the penile skin graft—an apparently successful innovation for plastic repair in this area.

Recovery was complete. Urinary and sexual functions were satisfactory.

Attention was directed to severe principles of plastic surgery applicable to this case. In addition, the question of thermoregulatory control of the testes by a surgically constructed scrotum was considered.

Nieburgs, H. E.; Medical College of Georgia; Augusta, Ga. "The Effect of Excessive Doses of Diethylstilbestrol on Carcinoma of the Cervix," Obst. & Gynec. Surv. 9:424-428 (June) 1954.

Diethylstilbestrol was administered orally in doses of 200 mg. to 500 mg. daily and in suppositories of 25, 50 and 100 mg. daily to patients with inoperable cervical carcinoma. Marked epithelization of the lesion and rapid hemostasis occurred in most cases. Cases following radiation therapy responded slower and patients with tissue necrosis following radiation therapy failed to respond. No untoward effects such as nausea, increased blood calcium or increase in tumor size were noted in patients kept on this therapy up to 75 weeks.

Attention is directed to the frequent escape from the effect of this hormone particularly during the first five to 10 weeks of therapy. As soon as spotting or bleeding recurs, the dosage should be increased by at least 100 mg. daily. Following the first 10 weeks of therapy an increase in dosage appears to be necessary only in intervals of 10 weeks.

Biopsies taken periodically revealed that this therapy produces solely palliation and is not offered as a cure. Stilbestrol administered to patients with cervical carcinoma results in rapid hemostasis by epithelization of the lesion with a great sense of well being to the patient.

Wall, Bithel; 1143 Druid Park Ave.; Augusta, Ga. "Pyelographic Changes in Necrotizing Renal Papillitis," J. Urol. 72:1-5 (July) 1954.

Necrotizing papillitis is a well established but infrequently diagnosed clinical entity, most cases being found at autopsy. Usually, but not always, it is found in patients with diabetes mellitus. Urinary tract complications of this disease are common, but pyelographic changes in clinical patients are rarely reported, there being only eight definite cases found before this publication. This report is concerned with three more such cases, in one of which the pyelographic changes were demonstrated before and after healing of the lesion, the first such case reported.

It is of utmost importance for physicians treating diabetes and urologists to be aware that this lesion causes characteristic pyelographic changes that will aid them in differential diagnosis of abnormalities of the calyceal architecture and, therefore, therapy indicated.

The clinical picture is one of CVA tenderness, pyuria, fever and often decreased renal function. The pyelographic changes are usually deformity, irregularity and cavitation of the renal calyx with enlargement of the kidney outline.

Although 85 per cent of the lesions occur in diabetics, many other causes have been suspected and reported and treated accordingly.

Treatment consists of correction of the underlying cause, i.e., if diabetic; insulin, antibacterials, etc. Prompt recognition of the entity and use of strict aseptic instrumental technique is essential in the proper management of this lesion.

Dramamine's® Effect in Vertigo

Dramamine has become accepted in the control of a variety of clinical conditions characterized by vertigo and is recognized as a standard for the management of motion sickness.

Vertigo, according to Swartout, is primarily due* to a disturbance of those organs of the body that are responsible for body balance. When the posture of the head is changed, the gelatinous substance in the semi-circular canals begins to flow. This flow initiates neural impulses which are transmitted to the vestibular nuclei. From this point impulses are sent to different parts of the body to cause the symptom complex of vertigo.

Some impulses reach the eye muscles and cause nystagmus; some reach the cerebellum and skeletal muscles and righting of the head results; others activate the emetic center to result in nausea, while still others reach the cerebrum making the person aware of his disturbed equilibrium. *Vertigo may be caused by a disease or abnormal stimuli of any of these tissues involved in the transmission of the vertigo impulse, including the cerebellum and the end organs.*

A possible explanation of Dramamine's action is that it depresses the overstimulated labyrinthine structure of the inner ear. Depression, therefore, takes place at the point at which these impulses, causing vertigo, nausea and similar disturbances, originate. Some investigators have suggested that Dramamine may have an additional sedative effect on the central nervous system.

Repeated clinical studies have established Dramamine as valuable in the control of the symptoms of Ménière's syndrome, the nausea and vomiting of pregnancy, radiation sickness, hypertension vertigo, the vertigo of fenestration procedures, labyrinthitis and vestibular dysfunction associated with antibiotic therapy, as well as in motion sickness.

Any of these conditions in which Dramamine is effective may be classed as "disease or abnormal stimuli"* of the tissues including the end organs (gastrointestinal tract, eyes) and their nerve pathways to the labyrinth.

Dramamine (brand of dimenhydrinate) is supplied in tablets of 50 mg. and liquid (12.5 mg. in each 4 cc.). It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. G. D. Searle & Co., Research in the Service of Medicine.



The site of Dramamine's action is probably in the labyrinthine structure.

*Swartout, R., III, and Gunther, K.: "Dizziness:" Vertigo and Syncope, GP 8:35 (Nov.) 1953.

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IMPORTANT NOTICE

**Annual Meeting, Georgia Chapter, American College of Surgeons
with
Georgia Urological Association and Georgia Society of Anesthesiologists
King and Prince Hotel, St. Simons Island, Sept. 30 and Oct. 1**

GUEST SPEAKERS

HUGH JEWETT, M.D., Assoc. Prof. of Urology,
The Johns Hopkins School of Medicine

NATHAN WOMACK, M.D., Prof. of Surg., Uni-
versity of North Carolina

WILLARD PARSONS, M.D., Chairman, Bd. of
Governors, American College of Surgeons
and Director of Surgery, Vicksburg Clinic,
Vicksburg, Miss.

SAMUEL MARSHALL, M.D., The Lahey Clinic,
Boston, Mass.

JOHN D. STEWART, M.D., Prof. of Surgery,
University of Buffalo School of Medicine

PAUL HAWLEY, M.D., Director, American Col-
lege of Surgeons, Chicago, Ill.

(Anesthesiology Speaker to Be Announced)

PANELS

Panel Discussions will be held on "Upper Abdominal Emergency Surgical Conditions" and "Graduate Training in Surgery."

ENTERTAINMENT

In addition to business meetings there will be sight seeing trips, golf, fishing and other sports. A fish fry and barbecue will be held Thursday night, September 30 and the annual dinner is scheduled for Friday night, October 1. You are invited. Make reservations direct.

Highlights of AMA House of Delegates Meeting

San Francisco, June 21-25, 1954

ONE OF THE MOST pleasant features of this meeting from our standpoint was the fact that we were able to seat our new delegate, Dr. Spencer Kirkland, Atlanta, as a third representative from the state of Georgia.

Thus we pass from the ranks of the "Aces and Deuces" to our new classification among the larger states.

As always, many interesting subjects were presented for our consideration at this meeting, among which were Closed Panel Medical Care Plans, Veterans Medical Care, Fee-splitting, Osteopathy and Training of Foreign Medical School Graduates.

The much publicized New York resolution calling for several changes in The Principles of Medical Ethics relative to participation in closed panel medical care plans was discussed at great length in reference committee. This is a plan to prevent such panels from advertising for members, and to furnish free choice of physicians to its members. This also involved the Kaiser Medical Care Plan for employees in Henry Kaiser's vast industrial interests in the west.

It was finally decided to refer this matter to the Judicial Council for a year's study. A report will be made at the next Annual Meeting.

The care of veterans with non-service connectable disabilities came up for much discussion, and our delegation introduced a resolution which had been sponsored by our former President, William Harbin. The resolution suggested that these cases be first carefully screened for merit and treated in civilian hospitals by civilian doctors under a voluntary health insurance program. This program would be financed by the government.

This as you realize was a modification of the Tennessee Plan, and we believe might have passed if the Tennessee Delegation had remained silent. However, they insisted on putting in their same plan which has been rejected many times. Our resolution was coupled with theirs and both went down to defeat.

The resolution on fee-splitting had to do with the subject of joint billing to some insurance companies. The Judicial Council offered no objection

to this but suggested that in most instances where two or more physicians render service to one patient they should render separate bills. The House of Delegates went on record as firmly opposing split fees, rebates or payment of commissions in any guise whatsoever. It further opposes any mechanism that encourages this practice.

Four resolutions dealing with the osteopathic problem were presented. The osteopaths want to be relieved of the cultist appellation. The request that there be more medical training in osteopathic schools and that more intercourse be encouraged between the two professions. The Judicial Council recommended that no action be taken on these matters until a direct, on-campus observation and study of osteopathic schools be made.

The question of foreign medical graduates, which is becoming quite a problem in some areas of the country, was referred to the Council on Medical Education and Hospitals for further study.

The House approved a Board of Trustees report for discontinuing the registration of hospitals by the Council on Medical Education and Hospitals, and the Joint Commission on the accreditation of hospitals was requested to undertake the registration of hospitals in addition to its present accreditation activities.

Dr. Elmer Hess of Erie, Pennsylvania, was named President-Elect of the A.M.A. and Dr. Clark Bailey, Kentucky, was named Vice-President.

The Distinguished Service Award of the A.M.A. went to Dr. Wayne Babcock of Philadelphia for outstanding contributions to medicine and humanity.

The House voted to continue the Annual Clinic Meetings.

It was announced that the California Medical Association had presented a check for \$100,000 to the American Medical Education Foundation.

The A.M.A. meets in Miami in November 1954, Atlantic City in June 1955, Chicago 1956, New York was chosen for 1957 and San Francisco 1958.

C. H. Richardson, M.D.

ANNOUNCEMENTS

The Ponce de Leon Eye, Ear Nose and Throat Infirmary, Atlanta, affiliated with the national Eye Bank for Sight Restoration, Inc., is offering its services for those who wish to donate their eyes to the eye bank at time of death. Physicians may obtain the necessary forms from the infirmary, which will make all arrangements after notification by the physician.

Fellowships for Basic Research in Arthritis—(1) Predoctoral fellowships ranging from \$1,500 to \$3,000 per annum, (2) Postdoctoral fellowships ranging from \$4,000 to \$6,000 per annum and (3) Senior fellowships for more experienced investigators will carry an award of \$6,000 to \$7,500 per annum. Deadline for applications is October 15, 1954. For information and application forms address the Medical Director, The Arthritis and Rheumatism Foundation, 23 West 45th St., New York 36, N. Y.

Courses

Course in Hematology: Nov. 18-20, 1954, presented by the Department of Medicine of the University of Florida in cooperation with the Florida Medical Association. Course to be presented by Dr. William Dameshek, Director of the Blood Research Laboratory, New England Center Hospital, Boston, Mass., his assistant, Dr. J. Komninos, and Dr. James N. Patterson, Tampa, Fla. There will be a \$25.00 registration fee. Further information can be secured by writing the Dept. of Medicine, Univ. of Florida, 1625 Riverside Ave., Jacksonville, Fla.

Meetings

Georgia Obstetrical and Gynecological Society—General Oglethorpe Hotel, Savannah, Ga., October 2, 1954. Guest Speaker Dr. Ralph Reis, Chicago, will speak on "Re-evaluation of Endocrine Therapy in Obstetrics and Gynecology."

Southern Medical Association—St. Louis, Mo., November 8-11, 1954. For further information write the Southern Medical Association, Empire Building, Birmingham 3, Ala.

Georgia Heart Association—General Oglethorpe Hotel, Savannah, Ga., September 24 and 25, 1954. Speakers include J. N. Morris, Medical Research Council of the United Kingdom, London, England; Willis J. Potts, Northwestern University, Chicago, Ill.; George E. Burch, Tulane University, New Orleans, La.; and Thomas Findley, Medical College of Georgia, Augusta. The Scientific Sessions are approved by the Georgia Academy of General Practice for post-graduate hours. For further information write to the Georgia Heart Ass'n., Inc., Western Union Bldg., Atlanta, Ga.

American Congress on Obstetrics and Gynecology—Palmer House, Chicago, Ill., December 13-17, 1954. For information write to the Sixth American Congress on Obstetrics and Gynecology, 116 South Michigan Ave., Chicago 3, Ill.

Annual Meeting of the Southern Trudeau Society, Sept. 9-11, 1954, Biltmore Hotel, Atlanta, Georgia, has been approved for post graduate credit hours for members of the American Academy of General Practice. Programs may be obtained from the Georgia Tuberculosis Association at 100 Chamber of Commerce Building, 33 Pryor Street, N. E., Atlanta, Georgia.

Tri-State Obstetric Seminar—Daytona Plaza Hotel, Daytona Beach, Fla., Sept. 13-15, 1954. Sponsored by the Maternal Welfare Committee of the Florida Medical Ass'n., the Maternal & Infant Welfare Committee of the Medical Ass'n. of Georgia, and the Bureaus of Maternal and Child Health—South Carolina, Georgia and Florida. Guest Lecturers include Fred L. Adair, Chicago; Allan C. Barnes, Cleveland, Ohio; Willis E. Brown, Fayetteville, Ark.; F. Bayard Carter, Durham, N. C.; Stewart H. Clifford, Boston, Mass.; Milton L. McCall, New Orleans, La.; William F. Mengert, Dallas, Texas; and Robert A. Ross, Chapel Hill, N. C. For further information write to the State Dept. of Public Health, Atlanta, Ga.

Joint meeting of the *Georgia Chapter of the American College of Surgeons*, the *Georgia Urological Association*, and *Georgia Society of Anesthesiologists*; King and Prince Hotel, St. Simons Island, Sept. 30-Oct. 1, 1954. For reservations write to the manager, King and Prince Hotel, St. Simons Island, Ga.

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Crawford W. Long Memorial Hospital

Georgia Baptist Hospital

Piedmont Hospital

St. Joseph's Infirmary

Emory University Hospital

Ponce de Leon Infirmary

DEATHS

DOWNING, ERNEST E., Newington, 70, died July 21, 1954, in a Savannah hospital after a brief illness. Funeral services were held July 22 at the Newington Baptist Church. Honorary pallbearers included J. C. Metts, Walter Usher, Harry Evans, J. H. Quattlebaum and G. T. Olmstead.

Dr. Downing was born in Screven County. He had practiced medicine in the vicinity of Newington since his graduation from the Medical College of Georgia in 1913. He was a charter member of the Newington Baptist Church and a member of the Newington Lions Club, the Newington Masonic Lodge and the Alee Shrine Temple.

"One of the most impressive things about Dr. Downing was the love and affection the people he served had for him. They had utmost faith in his ability as a physician and as long as he was able to move he worked hard in his efforts never to betray that faith." This is the tribute, in part, paid him in an editorial in the Sylvania Telephone.

HUTCHINS, JOEL THOMAS, Atlanta, 53, died July 12, 1954, after an illness of five weeks. Funeral services were held July 14 at Spring Hill with burial at Westview Cemetery in Atlanta.

Dr. Hutchins was born in Carl, Barrow County; he was graduated from the Emory University School of Medicine and did postgraduate work at the Mobile City Hospital. For many years he operated a clinic in the Lakewood Heights section.

Dr. Hutchins was a member of the St. Paul Methodist Church.

MIDDLEBROOKS, CHESTER O., Athens, 71, died July 21, 1954; he had been in poor health for some time. He had retired from active practice in 1942.

Dr. Middlebrooks was a native of Oconee County; he attended Gordon Institute in Barnesville and graduated from Atlanta Medical College, now Emory University School of Medicine. He opened his practice in Bogart and a few years later moved to Athens.

Dr. Middlebrooks served with the Army Medical Corps in the First World War. He was a member of the First Baptist Church of Athens.

MORRIS, JESSE S., Pearson, 65, died July 26, 1954, after a brief illness. Funeral services were held at Pearson First Baptist Church with burial in Sweetwater Cemetery.

Dr. Morris, a native Georgian, came to Pearson 41 years ago, immediately after his graduation from medical school. He had been chairman of the Atkinson County Board of Health since its organization. He served in the state legislature from 1930-32, and in the state senate for one year, 1933-34. He was also a former mayor of Pearson.

HENDERSON, CHARLES WILLIAM, Columbus, 62, died August 9, 1954, after a two-week illness. Funeral services were held August 11, 1954, in the chapel of the First Presbyterian Church of which he was a member.

Dr. Henderson was born in Arcadia, Fla., and received his A.B. degree from the University of Florida. He was a graduate of the Vanderbilt University Medical College. He retired from the Army Medical Corps with the rank of major five years ago, since that time he has lived in Columbus.

He was a member of the Academy of Ophthalmology and Otolaryngology, Columbus Rotary Club, Columbus Executives' Club, Columbus Country Club, Masons, and a Fellow of the Medical College of Surgeons. Dr. Henderson was the immediate past president of the Muscogee County Medical Society.

PERSONALS

The American College of Chest Physicians met in San Francisco, June 17-20, and elected the following officers for 1954-55: William A. Hudson, Detroit, President; James H. Stygall, Indianapolis, President-Elect; H. J. Moersch, Rochester, Minn., 1st V.-Pres.; B. L. Gordon, Philadelphia, 2nd V.-Pres.; C. K. Petter, Waukegan,

Ill., Treas.; A. H. Andrews, Jr., Chicago, Asst. Treas.; D. R. McKay, Buffalo, Chairman, Board of Regents; and CARL C. AVEN, Atlanta, Historian. OSLER A. ABBOTT, Atlanta, is Governor for the State of Georgia.

The Veterans Administration Hospital in Augusta has announced the addition of five new staff members to the medical center. They are W. R. BEDINGFIELD, a native Augustan; DAVID

E. TANNER, formerly of Sparta; DONALD H. MACDONALD, of the VA Regional Office in Atlanta; VICTOR A. MOORE, JR., a recent graduate of the Medical College of Georgia; and C. MARTIN RHODE, from the VA Hospital, Perry Point, Md.

BLAKE S. BIVENS, Ludowici, has recently completed his internship at the University Hospital in Augusta and become associated in the practice of medicine with O. D. MIDDLETON in the Middleton Clinic in Ludowici. Dr. Bivens is a native of Mount Vernon, Ga.

HENRY A. BRIDGES, Bainbridge, has announced that ASHBY WOODS, formerly of Harrisonburg, Va., is now associated in practice with him and the Bainbridge Hospital.

ROY CRAWFORD BROCK, Rome, has recently joined the staff of the Harbin Clinic in Rome. Dr. Brock received his M.D. degree from Emory in 1951, and since that time he has been in training at Grady Memorial Hospital in Atlanta.

J. MILLER BYNE, Waynesboro, was one of the two physicians of the class of 1900 at the Medical College of Georgia who attended the recent class reunion in Augusta. From a class of 60 graduates, six remain. The Georgians among them, besides Dr. Byne, are J. L. WEEKS, Harlem; and J. T. ARNOLD, Parrot.

WILLIAM R. CHAMBERS, Atlanta, announces the opening of his office for the practice of neurology and neurosurgery at 101 Third Street, N. E.

ELLISON R. COOK, Savannah, recently addressed the Exchange Club of Savannah. Dr. Cook's topic was the change of attitude that is developing among medical people as the profession comes of age. He said that the medical profession has finally realized that a patient is not a piece of machinery but a human being with a mind and a soul, whose background has much influence on his recovery.

P. K. DIXON, Gainesville, has announced his association with P. F. BROWN for the practice of surgery in Gainesville. Dr. Dixon is a native of Jonesboro and a graduate of Emory University School of Medicine in 1946.

H. GRADY ESTES and GRADY E. LONGINO, Atlanta, announce their association for the practice

of internal medicine, 343 Doctors Building, Atlanta.

HERBERT R. FROST and J. ROY ROWLAND, JR., Swainsboro, announce their association for the joint practice of medicine and general surgery in their new office building in Swainsboro. Dr. Frost and Dr. Rowland are 1952 graduates of the Medical College of Georgia; since that time they have been at Macon City Hospital.

JOHN A. HIGHTOWER, Brunswick, recently opened his offices for the practice of medicine at 502½ G Street. He has joint offices with E. R. JENNINGS.

Masons from Thomasville, Bainbridge, Moultrie and other points in Southwest Georgia gathered in Meigs recently for special ceremonies honoring JAMES N. ISLER, 80 year old member and past master of the Meigs Lodge. As a practicing physician in Meigs, Dr. Isler has delivered more than 2,000 babies.

GORDON JACKSON, Calhoun, recently became associated in the practice of medicine with WILLIAM PURCELL and CHARLES K. RICHARDS. Dr. Jackson is a native of Harrison; he is a graduate of the Medical College of Georgia.

J. C. METTS, Savannah, recently addressed the Kiwanis Club of Savannah.

MARVIN A. MITCHELL and THOMAS N. GUFFIN, Atlanta, announce their association for the practice of general surgery with offices at 490 Peachtree St., N. E., Atlanta.

A. P. OHLMACHER, Baxley, recently opened his office in the Dewey Moody home on Anthony Street. Dr. Ohlmacher will keep office hours in Baxley four afternoons a week.

J. C. PATTERSON, Cuthbert, recently spoke to the Cuthbert Rotary Club giving them a bird's eye view of his recent trip to Great Britain and Europe. After attending the conventions of the Royal College of Surgeons and the International College of Surgeons, Dr. and Mrs. Patterson, accompanied by other doctors and their wives, toured eight European countries.

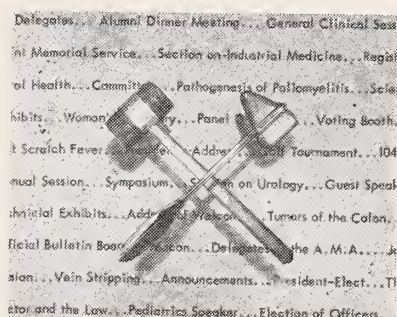
W. H. POOLE, JR., Elberton, has opened offices in Elberton for the general practice of medicine. He will be associated with JOHN B. O'NEAL on Chestnut Street. Dr. Poole is a graduate of the Medical College of Georgia.

SECOND CALL FOR SCIENTIFIC PAPERS

To Be Read Before

The 105th Annual Session,
Medical Association of Georgia

May 1-4, 1955, Bon Air Hotel, Augusta, Ga.



Titles of Papers Should Be Submitted Immediately
To the Respective Program Chairmen Listed Below

All Titles Must Be Submitted Before September 30, 1954

Radiology

L. P. Holmes, M.D.
753 Broad St., Augusta

Ga. Trudeau Society

Rufus Payne, M.D.
Medical College of Georgia, Augusta

General Practice

Fred Simonton, M.D.
Chickamauga, Ga.

Ophthalmology and Otolaryngology

J. Victor Roule, M.D.
Southern Finance Bldg., Augusta

Pediatrics

R. C. McGahee, M.D.
1345 Greene St., Augusta

Pathology

W. L. Sheppard
University Hospital, Augusta

Urology

J. Robert Rinker, M.D.
University Hospital, Augusta

Surgery

George Wright, M.D.
1345 Greene St., Augusta

Medicine

C. Purcell Roberts, M.D.
1211 W. Peachtree St., Atlanta

Chest Physicians

Levering Neely, M.D.
384 Peachtree St., Atlanta

Heart Association

A. Calhoun Witham, M.D.
University Hospital, Augusta

Orthopedics

R. R. McKnight, M.D.
1409 Gwinnett St., Augusta

Anesthesiology

Perry P. Volpito, M.D.
University Hospital, Augusta

Obstetrics and Gynecology

Charles Mulherin, M.D.
1528 Gwinnett St., Augusta

Industrial Surgery

Rufus Askew, M.D.
10 Pryor St. Bldg., Atlanta

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It has been announced that C. E. POWELL and H. WILDER SMITH, Swainsboro, have formed a partnership as of August 1st. The two doctors will maintain offices in the building formerly known as Smith's Hospital but which will now be known as the Powell-Smith Clinic.

J. L. RABB, Calhoun, has recently become associated with W. D. HALL and R. D. WALTER in the Johnston-Hall Clinic in Calhoun. Dr. Rabb is a graduate of the Medical College of Georgia and served his internship at the Crawford W. Long Memorial Hospital in Atlanta.

LEWIS RUIL SMITH, Eatonton and Macon, was married July 1, 1954, to Miss Shirley Ann Gibbs of Brunswick.

BIRD DANIEL, Statesboro, announced recently that ROBERT H. SWINT will be associated with him in the practice of medicine in Statesboro. Dr. Swint is a native of West Point, Ga., and a graduate of Emory University School of Medicine in 1951. From 1952 to 1954 he was resident surgeon at the VA Hospital at Chamblee, Ga.

WILLIAM J. TAYLOR, Lawrenceville, became associated in the practice of medicine with D. C. KELLEY, Lawrenceville, in July. Dr. Taylor is a graduate of the Medical College of Georgia, class of 1946. He practiced in Atlanta from 1948 until he entered the army in 1951. Dr. Taylor was stationed in Germany during his two year tour of

active duty; he was released from duty in February 1954.

Three surgeons have recently opened offices in Albany. ALBERT S. TRULOCK, JR., whose office is located at 121 Oglethorpe Ave., was formerly chief of surgical service at the VA Hospital in Montgomery, Ala. O. GREY RAWLS and T. GRAY FOUNTAIN have opened offices together at the Medical Building, 403 Broad Ave. Dr. Rawls completed his surgical residency at Lenox Hill Hospital, New York City, and Dr. Fountain, at Emory University Hospital. Both doctors have undergone training in the field of cancer at Emory University.

ISOM C. WALKER, JR., Savannah, has announced the opening of an office at 18 East Taylor Street, Savannah, for the practice of internal medicine and cardiology. Dr. Walker is a graduate of the Medical School of Duke University and served his internship at Grady Memorial Hospital, Atlanta. For the past two years he has been a resident in medicine at the Cincinnati General Hospital.

JOHN GRAY WELLS, Newnan, on July 22, 1954, opened his office at 41 Jefferson Street for the practice of internal medicine. Dr. Wells received his M.D. degree from the Johns Hopkins University Medical School in 1950 and received further training at Barnes Hospital, St. Louis, and Vanderbilt University Hospital, Nashville, Tenn.

Georgian's Attend Hawaii Meeting

The very successful meeting of the American Medical Association was closed in San Francisco only to be reopened on "the loveliest fleet of islands that lies anchored in any ocean." On June 26th at 1:00 a.m., 54 members of the medical family boarded the United Air Lines stratocruiser "Kanai" for the 16,407th crossing between the mainland and Honolulu. Many other doctors and their families made the crossing at other times. Clouds obliterated the view of Honolulu and its surroundings as we descended to the ground at 8:00 a.m., but the crowd on the ground was gay. Representatives of the Hawaiian Medical Association and their Auxiliary were on hand to greet us, bringing armfuls of leis. Dancing hula girls and Hawaiian music surrounded us. We



Left to right: Henry H. Tift, Macon; Mrs. Tift; L. L. Stanley, Surgeon on the "Lurline"; J. P. Culpepper, Miss.; Mrs. Eustace A. Allen; Dr. Allen, Atlanta; Mrs. Culpepper.

were ushered to limousines which took us to the Royal Hawaiian Hotel for a week filled with fun, music and medical scenes.

The summer meeting of the Hawaiian Medical Association began at 9:30 a.m., June 30th. Nils

P. Larson, President of the Hawaii Medical Association, opened the meeting with an address of welcome which was followed by a panel discussion on "Ulcerative Lesions of the Stomach and Duodenum." This meeting was held at the Mabel L. Smyth Memorial Building, named in honor of a nurse who devoted her life to the people of the Islands.

On Tuesday, the meeting was held at the Royal Hawaiian Hotel. Edwin K. Chung Hoon, Chief of the Medical Service, Division of Hansen's Disease, Department of Health, Honolulu, delivered a Pictorial Review of Leprosy. This was followed by a movie which threw the whole place into an uproar. It was on "Ventricular Excision for Leiomyosarcoma" and was a masterpiece of trick photography. That evening the medical society entertained at the famous Queen's Surf Club with a cocktail party and Luan (Hawaiian Feast)—all this to the accompaniment of wonderful music and dancing.

During the week's stay, there was little time or inclination to rest. Every moment was filled with exciting trips—to other islands, Pearl Harbor, and rides over all of Oahu Island.

Then came the time to wend our way homeward. About 80 doctors and their families re-

turned the leisurely way aboard the luxury liner Lurline. We pulled away from the "Aloha" dock at 4:00 p.m. Saturday, July 3rd. It was with rather heavy hearts that we tossed our leis into the bay earnestly making a wish to return to Hawaii.

The four days on the boat were most pleasant. The weather was fine, the sea was calm, but there was plenty of activity on board. The art of ukelele playing was mastered by Henry H. Tift of Macon and Mrs. Tift became an expert hula dancer. There were many parties, among them, those of Dr. and Mrs. Tift and Dr. and Mrs. George Lull of Chicago. On Saturday, July 4th, the captain of the Lurline gave a champagne party for all passengers.

Of course, doctors cannot get entirely away from their work, even at sea. On Sunday, one of the passengers developed acute appendicitis and was operated upon with success in spite of having 80 physicians at his beck and call. The ship's physician was assisted by two of our A.M.A. delegates. At last report the patient was well and back at work. So are all the rest of us . . . from a vacation that will be remembered as long as we live.

Eustace A. Allen, M.D.

Doctor Suggests Billing Medical Students

Solving the problem of deficit financing of the nation's medical schools by "billing" the graduate for his education after he is established in practice is suggested by Dr. Brian Bird in an article in the June issue of *The Journal of Medical Education*.

Dr. Bird, assistant professor of psychiatry at Western Reserve University School of Medicine, points out that for many years tuition charges have not been equal to the educational bill of medical students. Schools have met this situation by appeals for gifts from alumni, individuals, corporations, fund raising organizations, charitable foundations and, reluctantly, government agencies.

If costs continue to rise or private sources decrease, Dr. Bird believes that time would not be too distant when state schools would be the only ones able to pay their bills. This would mark the end of private medical schools, which many educators feel would be undesirable.

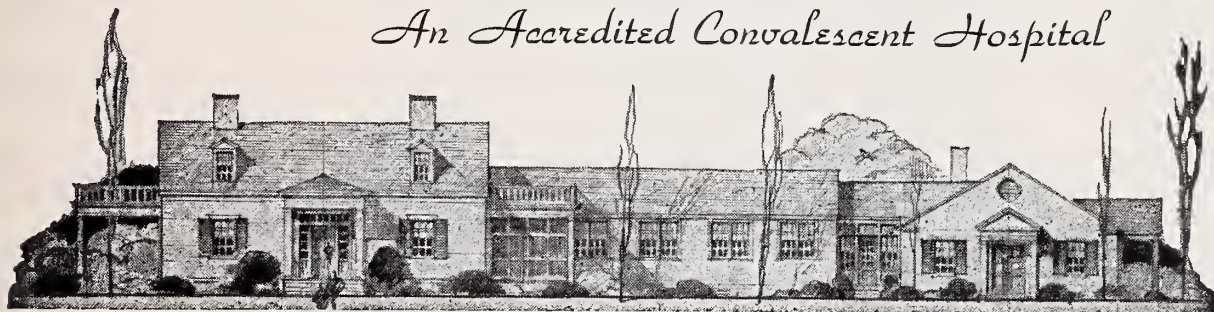
A way out of this dilemma, according to Dr. Bird, would be to regard the cost of medical school as a legal debt, which the student assumes with the understanding that he is to pay it back within a certain number of years after graduation. Dr. Bird feels it would work no hardship to ask them to pay in full for the education which enables them to earn so much. He says, "The doctor's role as a healer, a helper, a man of goodwill, must be preserved and can be preserved without cloaking him in a disguise."

The question of how the doctors who go into research and teaching instead of practice could pay their debts would be answered by raising their salaries so that they would be able to meet this obligation. Dr. Bird emphasizes that if tuition were raised to its full cost, and doctors were allowed to pay for their own education, the medical schools would be able to pay proper salaries to their faculties.

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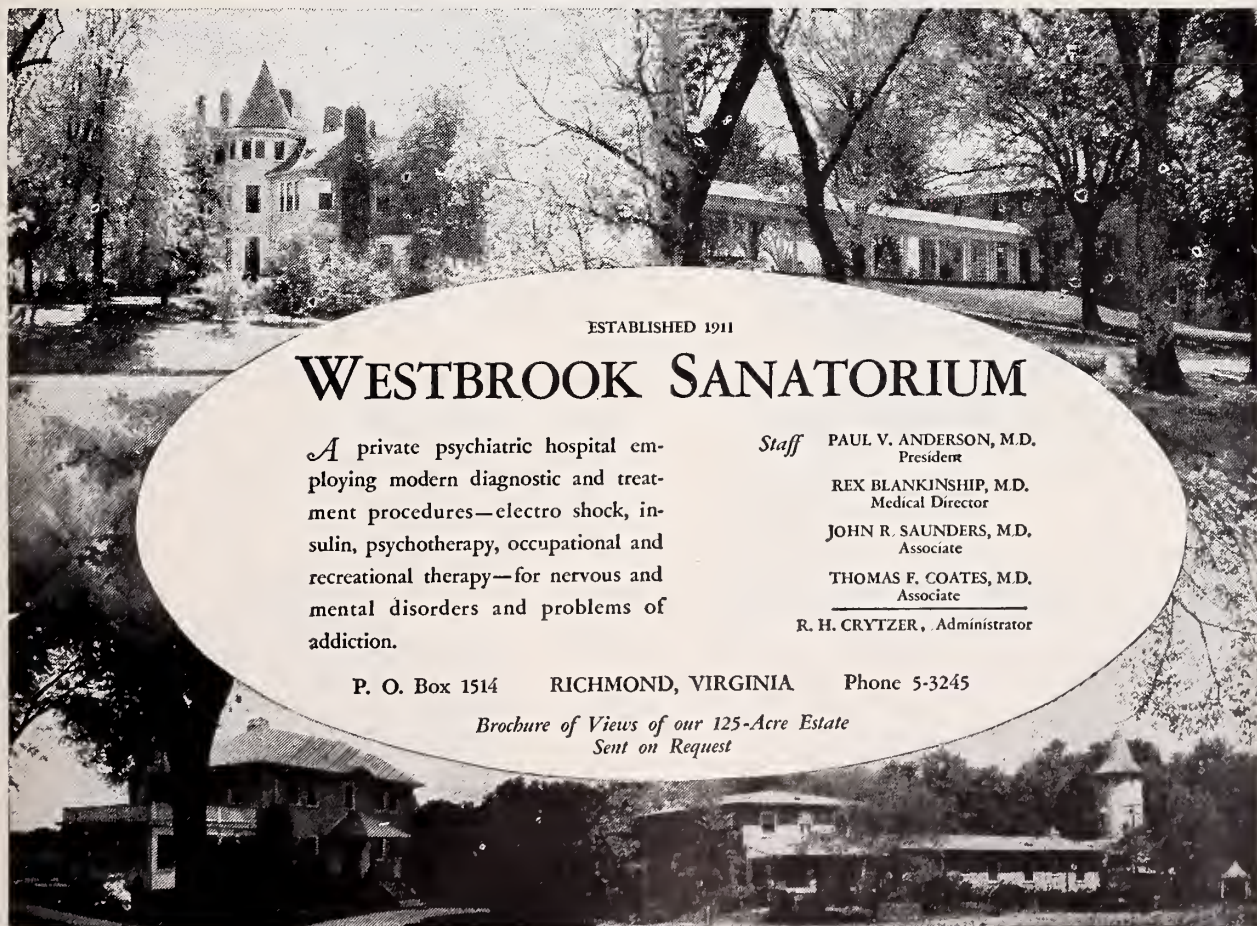
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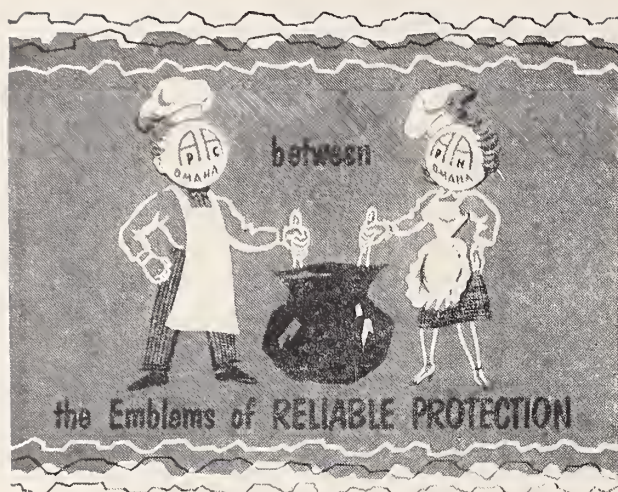
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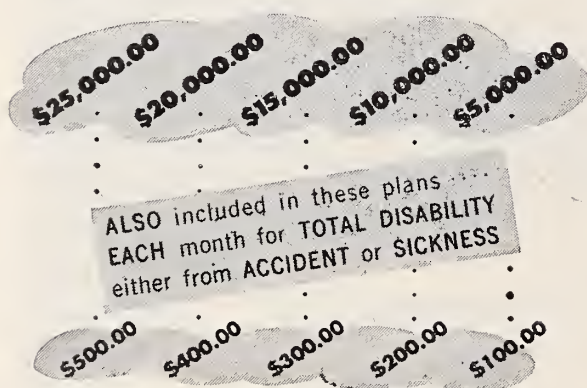
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*Heck, W.E.; Lynch, W.J., and Graves, H.L.: *Acta oto-laryng.* 43:416, 1953.

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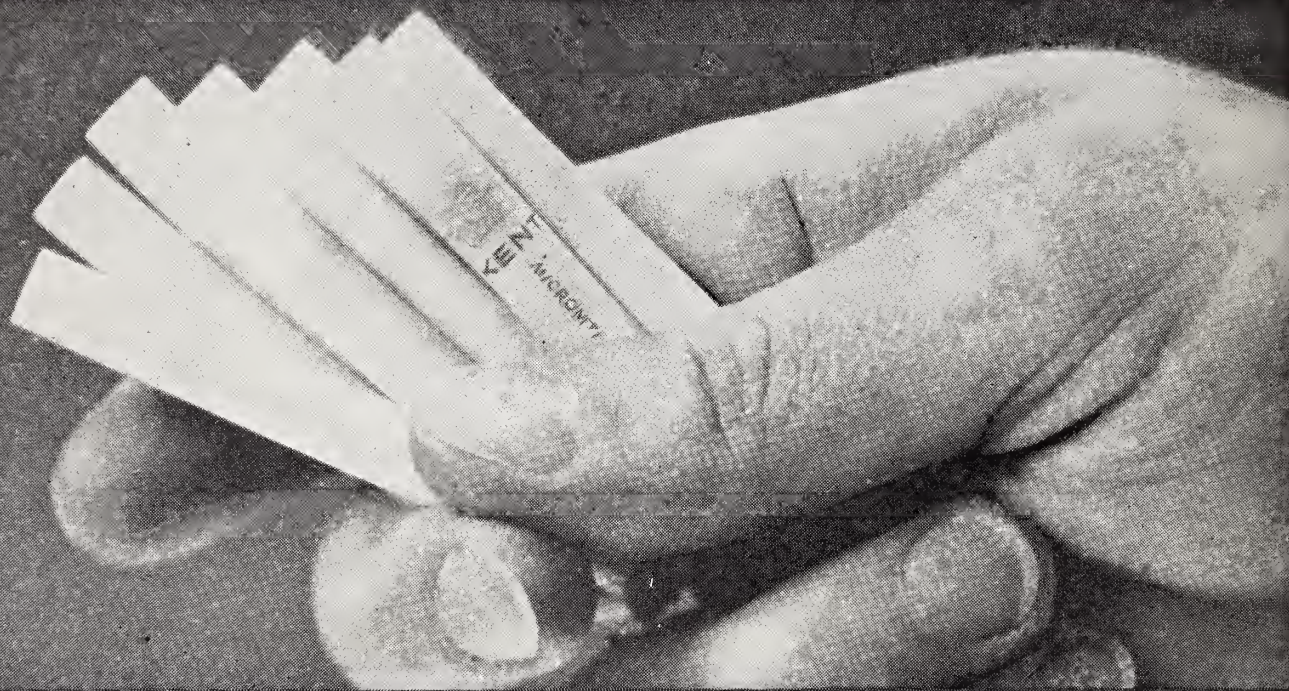
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1. Malleson, J.: *Lancet* 2:158 (July 25) 1953. 2. Goldzieher, M. A., and Goldzieher, J. W.: *Endocrine Treatment in General Practice*, New York, Springer Publishing Company, Inc. 1953, p. 23.

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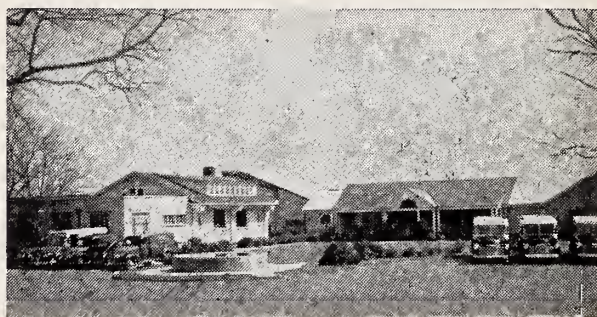
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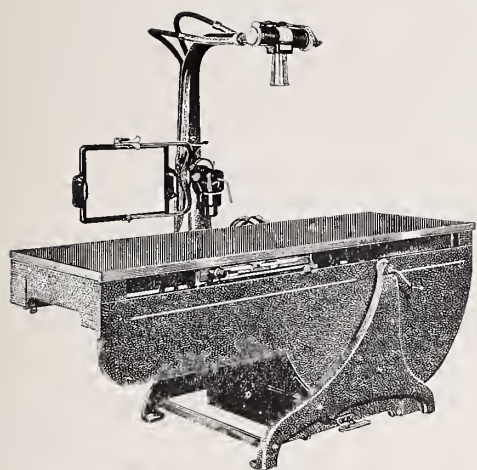
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Choice of a Digitalis Preparation

THE MANY PREPARATIONS and the manner of administration of digitalis have increased a hundred-fold since the Old Lady of Shropshire first administered fox-glove for "heart dropsy." However, the effects are essentially the same, and, despite strong opinions which have been expressed concerning the efficacy of one glycoside over another or over the whole digitalis leaf, the choice of preparation is largely a matter of personal preference. The physician should choose a preparation that is not expensive, for it may be needed for a long period of time. The important fact to remember is that when administered in adequate dosage each dose will produce a therapeutic effect, and there is no convincing evidence that one is clearly superior to the others.

The main indication for the use of digitalis is congestive heart failure. It is also useful in all of the auricular arrhythmias. When there is considerable cardiac hypertrophy, slowing of the rate is important because a thickened muscle needs a longer diastolic rest for oxygen diffusion. The digitalizing dose of the whole leaf is usually regarded as 0.1 Gm. per 10 pounds of body weight given in divided doses with the daily maintenance dose being 0.1—0.2 Gm. per day. This is, of course, the average digitalizing dose and must be tailored to fit the individual patient's needs. In general the dose varies inversely with age, with older patients requiring less per pound of body weight than children.

There are certain instances when special types of digitalis are indicated. Paroxysmal auricular fibrillation and paroxysmal auricular tachycardia may often be helped considerably by the judicious use of the drug, and it is here that the intravenous preparations are of greatest effectiveness. In such conditions an intravenous preparation of Lanatoside C® would seem to be the drug of choice. The average digitalizing dose of this product intravenously is 1.6 Mgm. with the maximum effect in one to two hours and a duration of action of two to three days. The principal danger in the

use of these preparations is that if the patient has recently been taking appreciable amounts of oral digitalis, intravenous preparations should be given with great caution and in smaller doses.

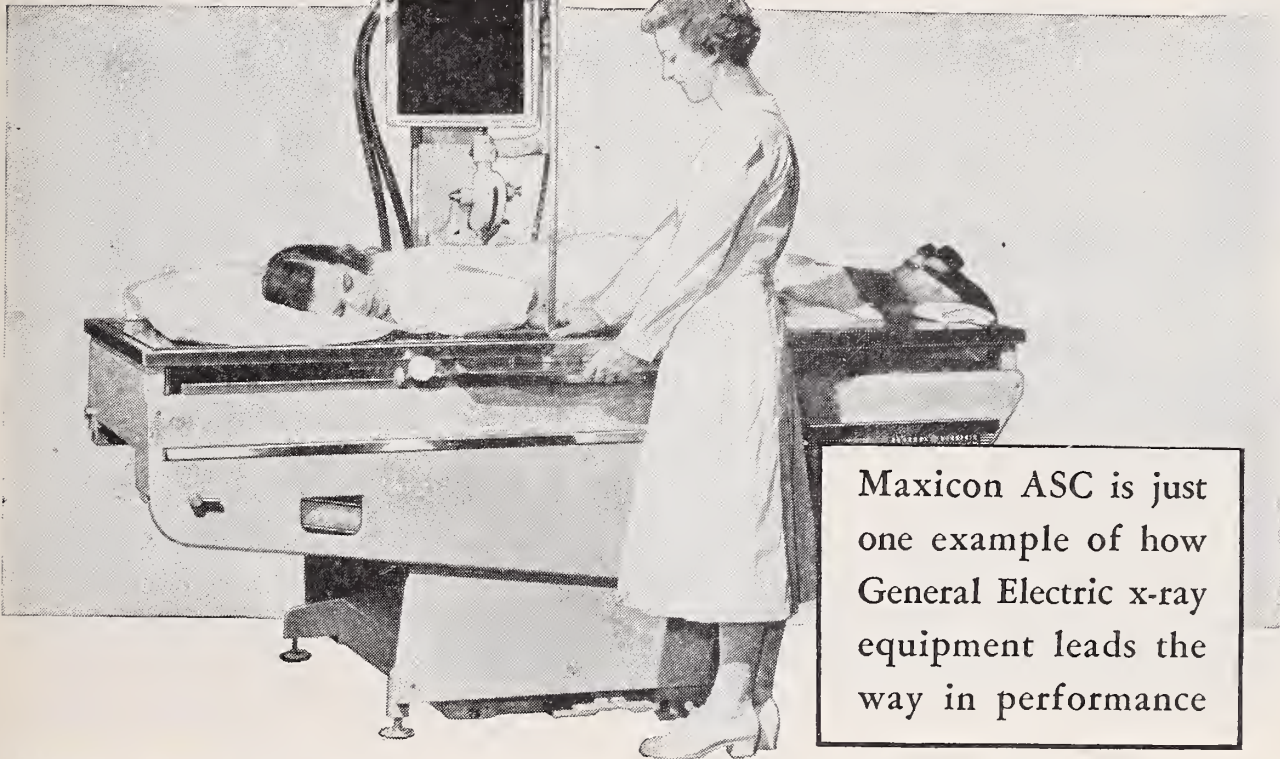
In certain special cases in which the patient cannot swallow pills, but can take liquids, a liquid preparation of digitalis must be used. In these cases, and also with children, one may properly try a liquid preparation of one of the newer purified glycosides. These preparations of liquid digitalis are much more effective and reliable than the old tincture of whole leaf whose true potency was never accurately known. Since these preparations are made from crystalline glycoside, their potency is always the same. It is possible to give the liquid preparations (diluted in 50 to 100 cc. of water) rectally to acutely ill patients.

In a seriously ill patient with a myocardial infarction who develops signs of congestive failure, digitalization is not without danger. In this case a highly purified but rapidly excreted preparation like Digoxin® should be used as it is completely and readily absorbed by the gastro-intestinal tract. The full therapeutic dose of Digoxin is considered to be 2.75 Mgm., and maintenance ranges from 0.25 to 0.5 Mgm. daily. The digitalizing dose can all be given at once or in divided doses. This product is more rapidly excreted, and toxic signs are more easily controlled than with the whole leaf or Digitoxin. The other purified products, such as Gitalin and Lanatoside C are similar in their action and are useful also in the patient who has been taking digitalis, but whose exact state of digitalization is not known.

Strophanthin and Oubain are preparations whose actions are similar to digitalis, but these are of great danger except in experienced hands. Their use is limited to intravenous dosage in emergencies.

It would seem that the important factor in digitalis therapy is to learn the action of the preparation of your choice well, and also to learn the special indications for the other types which must be used occasionally.

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FEATURE	MAXICON ASC	UNIT X	UNIT Y	UNIT Z
Table positions from 10° Trendelenburg to vertical	YES	YES	NO	YES
Variable speed table angulation	YES	NO	NO	NO
Radiation-protective table panels	YES	NO	NO	NO
18-in. focal-spot to table-top distance for fluoroscopy	YES	NO	NO	YES
Counterbalanced tube stand, providing adjustable focal-film distances up to 40 in.	YES	NO	NO	NO
Signal-light centering system for Bucky radiography	YES	NO	NO	NO
Provision for cross-table radiography	YES	NO	NO	NO
12-step line-voltage compensator	YES	NO	NO	NO
Automatic selection of large or small focal spot	YES	YES	NO	NO
45 x 78-in. or less space requirement	YES	NO	NO	NO

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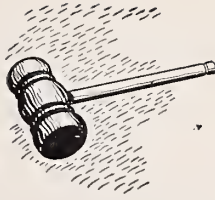
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president's page

The Georgia Medical Society will on October 13 and 14, 1954, have their Sesquicentennial Celebration in Savannah.

Of the active City Medical Societies in the United States, the Georgia Medical Society is the second oldest. It was organized and received its Charter December 12, 1804. The organization of this Society was the outgrowth of the realization of the dire need for better sanitation and medical care. It is interesting to note that of the Charter members only two were graduate Doctors of Medicine.

At the time of the organization of the Georgia Medical Society, Savannah was still a small community having an overall population of approximately 5,000.

Herbs, blisters, vomiting, purging and the liberal administration of calomel were the methods applied to medical cases. Surgical treatment consisted of bleeding, lancing of abscesses, splinting of fractures and reduction of hernias. The practicing physicians were either continentally trained or men serving apprenticeships under these doctors.

Since the first day of its existence this society has been active in promoting medical progress, and has constantly upheld the standards of organized medicine. The contributions of its members and the "pace of progress" set by them has "till this day" left its impact of force in the right direction.

Through the combined efforts of the members of the Georgia Medical Society, medicine and surgery as practiced in Savannah have reached a peak comparable with any medical center. With this trend, Savannah can do nothing but progress so far as medicine is concerned.

A bow of appreciation and admiration is in order for this Society.



Cytological Vaginal Smears

LESTER HARBIN, M.D., Rome, Ga.

SINCE THERE IS NOT at present any assurance that in the immediate future a certain cure for carcinoma will be forthcoming, the early detection of cancer of the cervix is the best weapon against this frequent malignancy. The advent of exfoliative cytology has made possible the detection of the carcinogenic process in the early or intra-epithelial stage. The cure rate in early carcinoma of the cervix or, so called carcinoma "in situ", should approach 100 per cent whatever the method of treatment, be it radiological or surgical. In contrast to this amazing possibility of a 100 per cent cure for pre-invasive carcinoma of the cervix is the fact that at present the world-over average cure rate for squamous cell carcinoma of the cervix is only 30 per cent. Three quarters of all female genital cancer is epidermoid carcinoma of the cervix. It therefore behooves the profession at large to avail itself of this valuable diagnostic procedure. The routine annual use of the cytological vaginal smear in all females above the age of 18 will reveal many early or pre-invasive carcinomas of the cervix. All suspicious or positive smears should be confirmed by biopsy before any form of therapy is

instituted. Complete dependence on biopsy, as has been customary in the past, will limit the scope of the tissue area examined. The smear method is a diffuse biopsy method since cancer cells shed more rapidly than do normal cells, and the vagina is the natural repository for these abnormal cells. The smear and biopsy techniques are complementary, and there are advantages and disadvantages to each method.

During the past three years 17,403 cytological vaginal smears in the Floyd County area have revealed 76 cases of carcinoma of the cervix, and all have been confirmed by biopsy. In addition, 351 patients had smears which revealed slight nuclear changes of a benign nature. These patients are being kept under observation by repeated cytological examinations.

It is the combined opinion of those involved in this program that this is a valuable and life-saving procedure. If and when it is practical for all women to have a vaginal smear for cancer every 12 months, then the problem of carcinoma of the cervix can be solved. All practitioners who treat women should do this test on all of their female patients at least once each year.

Harbin Clinic

See "Medic" on NBC-TV

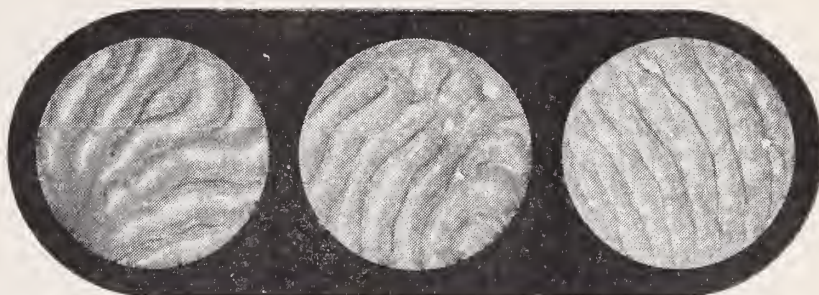
Of special interest to all TV-viewing physicians is NBC-TV's revolutionary new program, "Medic", which was first beamed across the country Sept. 13. Sponsored by the Dow Chemical Company, this new "Dragnet"-type show will bring to millions of Americans a better understanding of the role of modern medicine in their daily lives.

A dramatic, informative and authentic program, its various doctor-patient sketches touch on all

phases of life, both historical and contemporary. No single character will run through the series, but medicine itself will be the "star."

"Medic" is being presented Monday evenings at 9 p.m. EST, three times monthly. Producers are ex-"Dragnet" writer James Moser and veteran TV and stage producer Worthington "Tony" Miner. The Los Angeles County Medical Association will lend technical assistance.

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References: 1. Hollander, F.: Arch. Int. Med. 93:107 (Jan.) 1954
2. Deutsch, E.: Scientific Exhibit, Gastroscopy, Interim Session A.M.A., St. Louis, December, 1953



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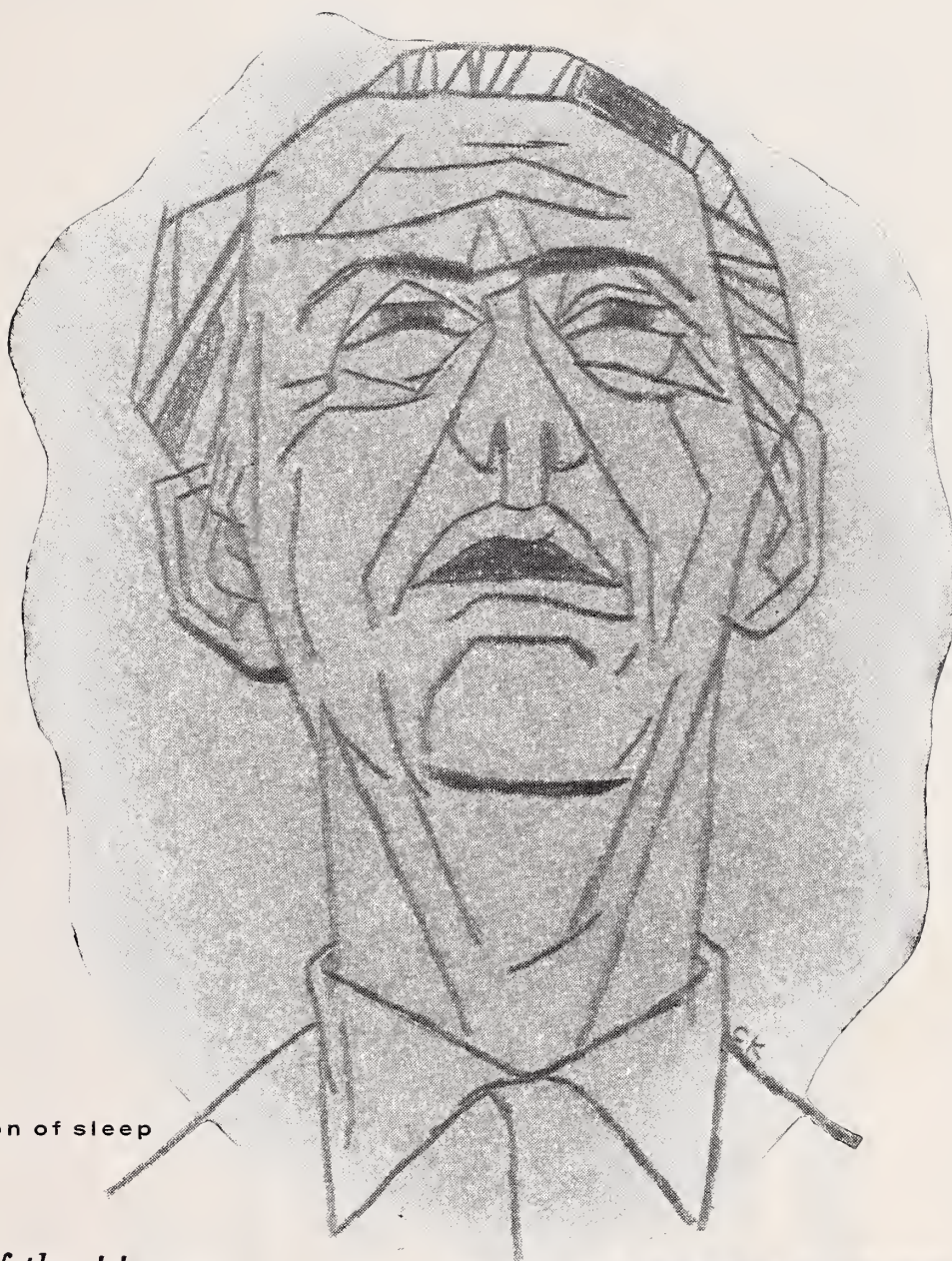
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the executive secretary's letter

Aid If Necessary

Due homage should be paid the county medical society secretary; his task is difficult, to say the least. To ease the load somewhat, MAG headquarters is preparing a County Medical Society Secretaries' PORTFOLIO. This kit will contain a thousand answers to society organization problems. AMA, MAG and a model county society constitution will be enclosed plus information on membership requisites, types of membership, dues and assessment data, MAG Delegate rules, etc. A meeting minutes notebook will be in the kit for recording all society business.

Dedication

It is well to remember that this issue of the *Journal* commemorates the 150th anniversary of the founding of the Georgia Medical Society, second oldest medical society in the United States. A county medical society is the "Granddaddy" of medical organizations, and it is the county medical society that is the basic unit of organized medicine.

Annual Session Papers

Last call for physicians wishing to present papers at the scientific sessions of the MAG 105th Annual Session, Bon Air Hotel, Augusta, May 1-4, 1955. Section program chairmen must have their programs complete by October 15. Send all papers to designated section chairmen now (see inside of back cover).

A Repeat

For clarification concerning eligibility of LIFE MEMBERS please note: A physician who is an MAG member in good standing having been an MAG member for 40 years or having passed his seventieth birthday is eligible for Life Membership in the MAG if the physician's county medical society will recommend him to the MAG for this type membership. This recommendation from the county medical society is then given to the MAG House of Delegates for approval and goes into effect the first of the year after the approval. Life Members are exempt from the payment of MAG dues but have all privileges and rights of membership which include the right to hold office and vote, medical defense and the *Journal*.

Over the State

MAG Headquarters Office policy of visiting all county medical societies is going well. With

some 80 societies to visit, about one-half remain on the near-future list. In a tabular breakdown of the component society membership, the following figures were obtained: one society with over 200 members; four societies with from 100 to 200 members; 14 societies with from 30 to 50 members; 28 societies with from 10 to 20 members; and 30 societies with 10 members or less.

Standing Room Only?

To insure adequate accommodations at the 1955 MAG Annual Session it's the "right time to write" for your hotel room reservations. Drop a note to: Dr. David R. Thomas, Jr., Chairman; MAG Hotel Reservations Committee; Bon Air Hotel; Augusta, Georgia.

All Georgia GP's

It's more than just difficult to know everything about all the phases of GP medicine—but you can get a pleasant refresher by attending the Georgia Academy of General Practice Sixth Annual Session, Biltmore Hotel, Atlanta, October 20-21. Outstanding speakers are scheduled to speak on GP subjects. On the social side, the Biltmore Ice Show is booked for the Annual Banquet the evening of the 20th.

Association History

The August 28 issue of the JAMA contains a short history of the MAG. Featured in the article on page 1585 is a description of the first meeting of the Association in 1849 when 70 Georgia physicians gathered together to found the organization. The first president was Dr. Lewis DeSaussure Ford, Dean of the Medical College of Georgia. A picture of the Academy of Medicine, where the MAG headquarters is maintained, accompanies the article.

Dates to Remember

With the coming of autumn, a rash of medical meetings has broken out. Don't forget the following . . . October 7, Second District Meeting, Thomasville . . . October 12th and 13th, Georgia Medical Society, Sesquicentennial celebration . . . October 12, Eighth District Meeting, Brunswick . . . October 20 and 21, Sixth Annual Session, Georgia Academy of General Practice . . . November 4, Fifth District Meeting, Academy of Medicine, Atlanta.

Milon D. Krueger

Executive Secretary

the month in washington

Medical Legislation

Washington, D.C.—This is a report of the final status of the important medical legislation at the adjournment of the 83rd Congress. Congress rejected the only major part of the Eisenhower health program opposed by the A.M.A.

The administration bill to streamline the Public Health Service grants was passed by the House but failed in the Senate.

Congress lowered the medical expense tax deduction from five per cent to three per cent, doubled the maximum limitation on deductions, and liberalized other health and drug tax features.

Other measures of medical interest which became law included: (a) transfer of the Indian hospital and medical service from the Indian Bureau of the Department of the Interior to the Public Health Service of the Department of Health, Education and Welfare; (b) a federal

charter for the National Fund for Medical Education; (c) prohibition of the shipment of fireworks into a state where their sale is illegal; (c) extension of the doctor draft act to 1955, strengthening the Defense Department's position in delaying the drafting of physicians and dentists who might be security risks.

Congress rejected the Bricker constitutional amendment to restrict the government's treaty making powers. Congress also declined to act upon: (a) a number of bills to make it a presumption that certain diseases were incurred from a veteran's military service, rather than decide on a scientific basis; (b) bills to permit self-employed persons to take tax deductions for their personal pension annuities; (c) legislation to offer free medical care to the dependents of military personnel; and (d) a bill to permit the federal government to contribute with its employees in purchasing health insurance.

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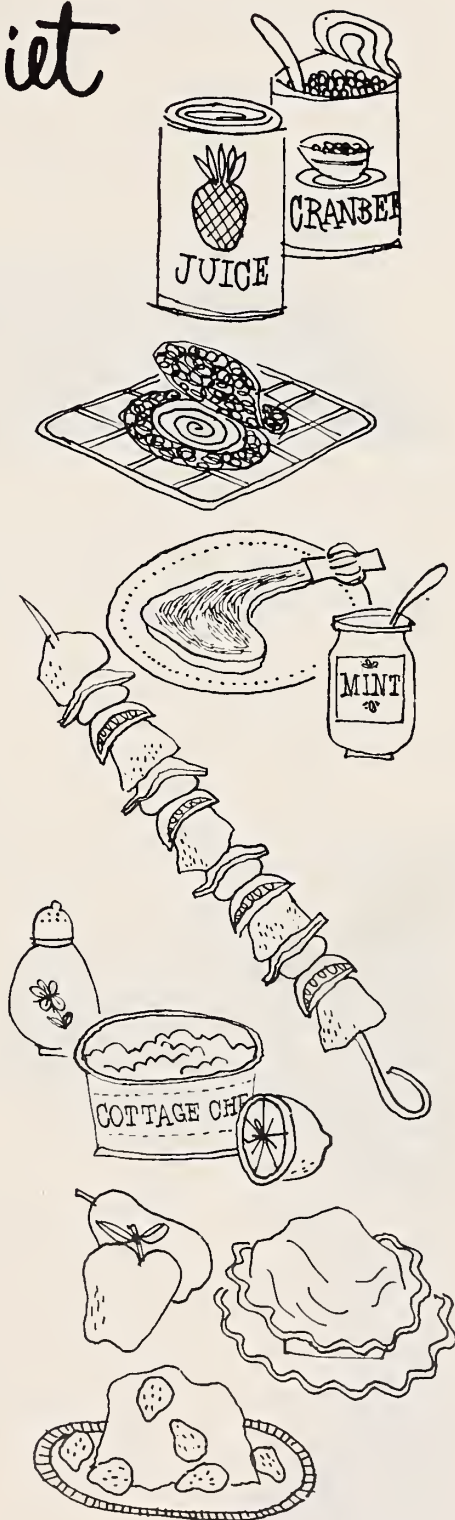
Meat loaf can sport a gay cap of whole-cranberry sauce, while hamburgers make a surprise party when a slice of pickle or onion is sealed between two thin patties. Your patient can baste chicken with lemon or orange juice—glaze lamb chops with mint jelly. Lean meats, broiled or baked, are made savory with herbs. And barbecued kabobs add something different.

Most vegetables can be dressed simply with lemon juice or an herb vinegar. And tomato halves come out from under the broiler bubbly with brown sugar and sweet basil on top.

On green salads, cottage cheese thinned with lemon juice, sparked with paprika, makes the dressing. And on fruits, try lemon juice, honey and chopped mint.

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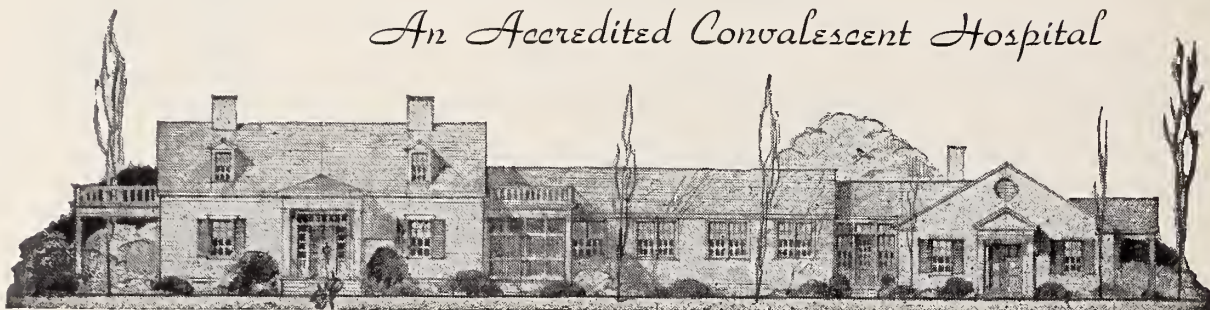
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abstracts by georgia authors

Kite, J. Hiram; Doctors Bldg.; Atlanta, Ga. "Torsion of the Lower Extremities in Small Children", *J. Bone & Joint Surg.* 36-A:511-520 (June) 1954.

Torsion of the lower extremities in small children usually makes one of two patterns. The children may have medial torsion and be bow-legged and pigeon-toed, or they may have lateral torsion and be slightly knock-kneed and flatfooted.

Medial torsion should be considered in two groups—congenital and acquired—because of differences in etiology and in treatment.

In the congenital group the torsion is chiefly between the knee and the ankle, and there is a marked lateral convexity to the leg. It may either be an atavistic reversion or a developmental arrest. This group may need braces for correction if it does not respond to conservative treatment.

In acquired medial torsion the limbs are straight at birth, but the deformity is produced by the position in which the child sleeps and sits. The deformity in this group is more easily corrected and responds to manual stretching.

Lateral torsion is the reverse of the medial torsion. It is produced by the baby sleeping on his stomach with the legs in the frog position most of the time. The foot is forced into a flat-foot position. This is probably the cause of most of the flat-foot deformities seen in children.

Berger, I. R. and Cowart, G. T., 5998 Peachtree Rd., N. E., Atlanta, Ga. "Renal Echinococcus Disease", *Radiology* 62:852-857 (June) 1954.

Hydatid disease is an uncommon occurrence in this country. It is likely, however, to show an increased incidence in the next few years because of the exposure of our troops overseas to the intestinal tapeworm of the dog during the second World War. Renal involvement occurs in from two to 9.6 per cent of all cases of echinococcosis. The authors report the 37th case of renal hydatid disease recorded in the American literature, apparently only the second case suspected preoperatively without evidence of the disease in the urine.

In this report the etiology, pathology, symptomatology, diagnosis, prognosis and treatment of renal echinococcus disease are thoroughly discussed. The life cycle of the *Taenia echinococcus* is reviewed.

Diagnosis is based on the finding of daughter cysts or membranes in the urine, the demonstration of a renal mass, eosinophilia, and complement-fixation and intradermal tests.

Weens, H. Stephens; Clements, J. Luther; & Tolan, John H., Emory University School of Medicine. "Radiation Dosage to the Female Genital Tract During Fluoroscopic Procedures", *Radiology* 62:745-749 (May) 1954.

Radiation exposure of the female genital tract during radiodiagnostic examination has received increasing attention with regard to the possible production of genetic damage. Also recent experimental studies have shown that the intrauterine fetus is unusually sensitive to radiation during certain early phases of gestation. Radiation exposure of ovaries and uterus incident to radiographic examinations may be determined with reasonable accuracy by phantom experiments. Radiation exposure during fluoroscopic procedures is however more difficult to determine on account of such variable factors as fluctuating field sizes, differences in duration of fluoroscopic observations and changes in position of the patient.

In order to provide more precise information, the authors have experimentally determined radiation exposure of the female mid-pelvis during fluoroscopic examinations of the colon and upper gastrointestinal tract by introduction of a midjet ionization chamber into the vaginal fornix of 15 patients undergoing routine examinations (Barium enemas and G.I. series). Radiation dosage to the female genital tract during Barium enemas was found to be between 0.3 and 0.8 roentgens, and during G.I. series between 0.1 and 0.3 roentgens. These dosages proved to be somewhat smaller than had been anticipated. Various technical factors influencing these dosages as well as measures to reduce these radiation exposures are briefly discussed.

Chambers, William R., 101 Third St., N.E., Atlanta, Ga. "Experiences in Severe Intractable Headaches," *Sou. Med. J.* 47:741-745 (Aug.) 1954.

A classification of headaches into the following twelve sub-divisions gives a practical basis for history taking and examination: (1) Tension headache, (2) Migraine, (3) Myalgia, (4) Post-traumatic, (5) The ear, the eye, the nose, and the teeth, (6) Brain Tumor, (7) Allergy, (8) The Neuralgias, (9) Systemic Diseases, (10) Toxic, (11) Congenital and acquired malformations and (12) Epilepsy Equivalent. This schedule is in the approximate order of incidence.

In the study of chronic headache, the history and examination can be concentrated about the head and neck, as the vast majority of causes will be identified by local manifestations.

Each subdivision will have a characteristic pattern. Tension headache must have a time and place relationship to an irritating situation, and it is relieved by distracting occupations or a good cry.

Migraine is episodic, one sided and long lasting, evidenced by visible pulsation of the temporal artery, and improved by pressure on the artery.

Myalgia is a constant, nagging occipital headache associated with tender nodules along the neck muscles; it is often improved by procaine injections.

Post traumatic headache is self limiting, seldom lasting over three months.

Brain tumor should be suspected whenever the headache is of recent origin, gradually progressive, recurring in the same location and awakening the patient early in the morning.

Allergic headache is unilateral, excruciating, episodic, of short duration, often associated with stuffiness of the nose and tearing of the eye.

Examination should include the otoscope, ophthalmoscope, nasopharyngoscope, spinal tap, x-rays of skull and neck, and local procaine injections as well as provocative injections of histamine, and therapeutic trial of adrenalin, ergotamine, dihydro cortisone and neck stretching.

Chambers, William R., 101 Third St., N.E., Atlanta, Ga. "Surgery for Spontaneous Intracerebral Hematoma in the Geriatric Patient," *Geriatrics* 9:390-391 (Aug.) 1954.

There are many reasons for desiring the survival of an older person. If the chances are good for a reasonable degree of recovery, then the denial of surgery on the basis of age is unfair to all concerned. Considerations other than age may outweigh it in predicated recovery to the point where life may be enjoyed.

The first of these is whether or not the patient is ever in coma. There is a small percentage who never suffer from coma. The prognosis for this group is much better. The second is whether any signs of improvement occur in the first 48 hours. If so, the outlook is still more favorable. The third is whether a source of the bleeding, such as an aneurysm, can be found. In such a case, the intracerebral clot is likely to be in a more favorable position for operation. If the vascular anomaly itself is amenable to treatment, the outlook is favorable. The fourth is the position of the clot, with or without a known source of hemorrhage. The fifth is whether there is a history and findings of generalized arteriosclerosis. Cardiovascular renal sclerosis is a major contraindication.

Three case reports are related. One 75 year old woman was never in coma, did not show signs of arteriosclerosis out of proportion to her age, and had a clot in a favorable position. In spite of her age, she has had considerable recovery. One 67 year old woman showed improvement in her state of consciousness, no evidence of arteriosclerotic disease, and a clot in a favorable position. In spite of her age, her recovery has been remarkable. One 52 year old man was never in coma, had a demonstrable source of hemorrhage, with a clot in a favorable position. Recovery is virtually complete.

Fincher, Edgar E., Emory University School of Medicine, Emory University, Ga. "Experiences with Meningiomas," *The Surg. Clinics of No. America* 34:1037-1949.

These reputedly benign neoplasms, even though amenable to skillful surgical removal, carry a severe morbidity and differ greatly in their growth characteristics as well as their clinical behaviors. The significance of the clinical features of these growths has been, by most authors, relegated to the fine print of statistical charts or received secondary consideration *in lieu* of most optimistic statements regarding their "benign nature and surgical accessibility." A common impression is that the brain is simply compressed by these meningiomas and therefore removal is followed by "practically complete restoration of function." It has been the author's opinion that these benign tumors are a redoubtable group for the neurosurgeon. One hundred consecutive cases were reviewed from the author's personal experiences.

Of the 100 cases, 99 were operated upon for a total of 128 surgical procedures. There were 14 surgical mortalities. In the follow-ups nine deaths were attributed to meningioma recurrences and nine deaths due to unrelated intracranial disease. No cases of meningitis in the series, five osteomyelitic complications. Of 68 living patients, (one to 20 years) 44 had some physical or neurologic deficit as result of their benign tumors. A morbidity of 52 in the 99 surgically treated patients.

This article will be no more than a reminiscent stimulus to the seasoned neurosurgeon. The intimations and experiences as recorded by the author should temper the inexperienced cranial surgeon's optimism in treating these "benign tumors."

Gay, B. B. and Bonmati, Jose, Emory University Hospital, Emory University, Ga. "Primary Neurogenic Tumors of the Lung and Interlobar Fissures," *Radiology* 63:43-47 (July) 1954.

Neurogenic tumors most often occur in the posterior mediastinum. Rarely they arise primarily in the lung or interlobar fissures. Only 15 cases of neurogenic tumors of the lung and interlobar fissures could be found in the literature. Two additional cases are reported in this communication. There are no specific clinical or radiologic findings to suggest the diagnosis. Most often the roentgenogram will reveal a well circumscribed homogeneous density, rounded or lobulated, without calcium content. Treatment is surgical.

Harris, Ad., Olansky, Sidney, and Bossak, H. N., Communicable Disease Center, U. S. Dept. of Public Health, Atlanta, Ga. "Comparative Reactivity of the VDRL Slide and Other Tests for Syphilis in Random Population Groups (Including *Treponema Pallidum* Immobilization Tests)," *Am. J. Syph., Gonorr. & Ven. Dis.* 38:295-303 (July) 1954.

The VDRL Slide, Kline Standard, Rein-Bossak and Mazzini Flocculation Tests were performed on 2,560 blood specimens from random field surveys in South Carolina. The VDRL Slide Test produced fewer positive and weakly positive reactions in the serologically unselected group of volunteer donors than did the Mazzini, Kline Standard or Rein-Bossak Slide test. Findings reported indicate that a greater number of randomly collected blood specimens would probably produce positive reactions in the TPI test and negative reactions in the VDRL Slide test than would show the reverse type of disagreement in these two serologic tests for syphilis. No one of the five tests used, that is, the VDRL Slide, Mazzini, Rein-Bossak, Kline Standard or TPI agreed in all instances with the diagnoses referring to present patient status or previous syphilitic infection.

King, Richard E., Blalock, J. C., and Lovell, Wood M., Georgia Baptist Hospital, Atlanta, Ga. "An Unusual Spine Lesion, Possibly Typhoid (Report of a Case)," *J. Bone & Joint Surg.* 36:863-866 (July) 1954.

The history, physical and laboratory findings of a case of typhoid osteomyelitis of the body of L-2 are presented. Certain features of the clinical course of the disease are elaborated as an aid in making the diagnosis.

Rumble, Lester, Jr., St. Joseph's Infirmary, Atlanta, Ga. "Premedication in the Aged Patient," *Sou. Med. J.* 47:651-653 (July) 1954.

The major cause of anesthetic fatality, and probably much of anesthetic morbidity, is a partial or complete lack of oxygen, coupled with an inadequate removal of carbon dioxide. Elderly individuals are particularly susceptible to the effects of depressant drugs. Premedication of individuals over 60 years of age must be adequate, but not excessive.

The principles of premedication in aged patients are summarized:

1. Premedication must be individually tailored to fit each patient in light of the type of anesthesia and the operation to be performed.

2. It is preferable to err on the side of too little than to chance the harmful effects of overdosage.

3. Aged individuals are already on a downhill grade. Their tolerance is decreased and their reserve depleted.

4. Ample time must be allowed for the effects of the premedicant drugs, before the additional depression of anesthesia is added.

5. In elderly patients, even more than in the young, attention to detail pays dividends.

Prince, Charles L., Scardino, Peter L., Finkle, Alex L., 2515 Habersham St., Savannah, Ga. "Undiagnosed, Gross Renal Bleeding," *J. Urol.* 72:111-116 (Aug.) 1954.

The largest series of cases of unexplained, gross renal bleeding without evidence of pyelographic deformity to be found in the literature is presented. There were 19 cases, most of which occurred in males under 45 years of age. Complete urological studies were ineffective in identifying the cause or renal site of the hematuria. Nine patients enjoyed spontaneous and seemingly complete remission without treatment. Two others were relieved apparently following eradication of "focal infection." Five nephrectomies were performed because of profuse bleeding or suspected tumor. In none of the surgical specimens could histopathology be demonstrated to explain adequately the renal bleeding observed clinically.

No method of improved diagnostic facility was found. Conservatism, in order to avoid hasty nephrectomy, was recommended.

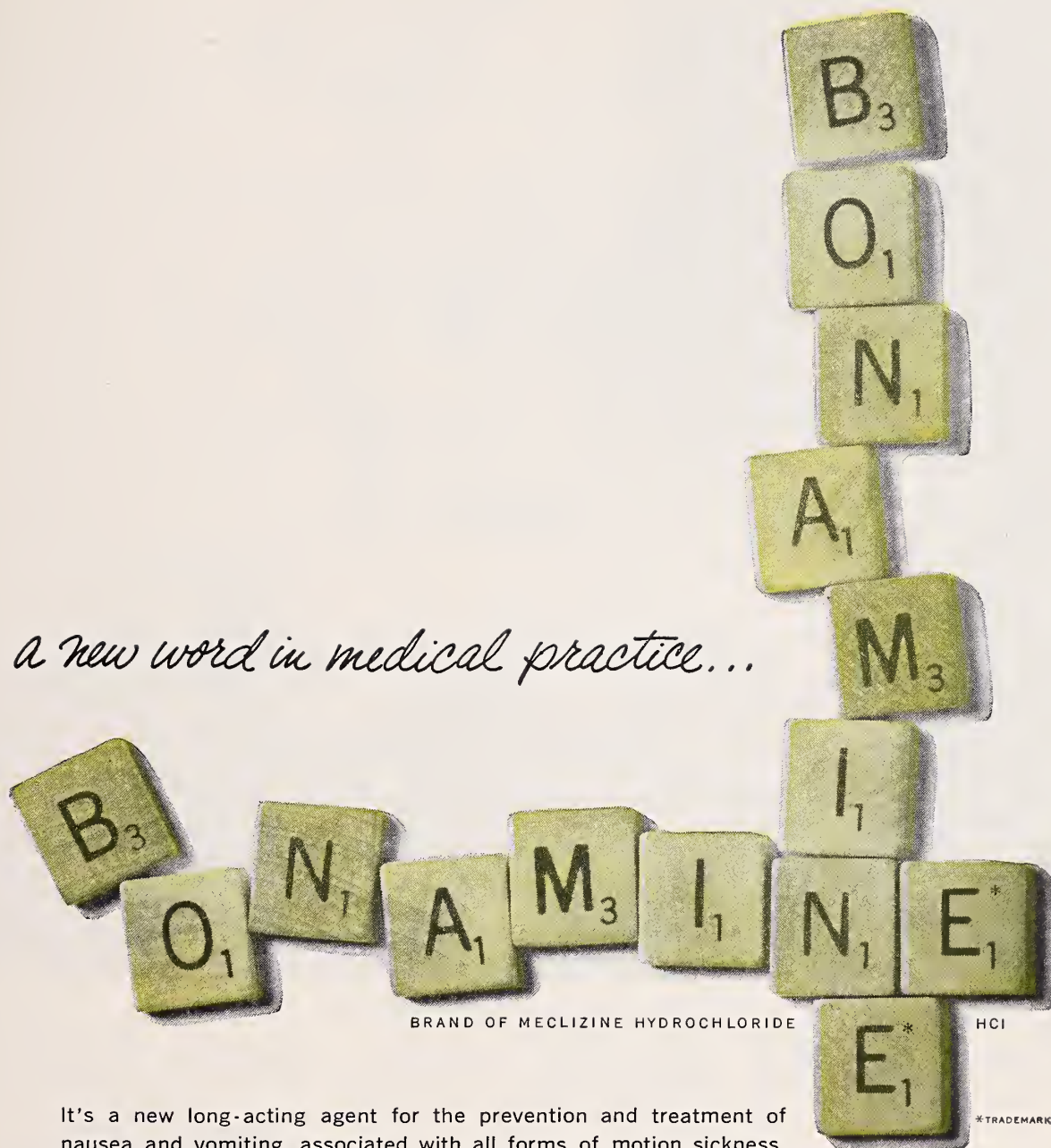
Brooke, M. M., Donaldson, Alan W., Brown, Eugene, Communicable Disease Center, Dept. of Public Health, Atlanta, Ga. "An Amebiasis Survey in a Veterans Administration Hospital, Chamblee, Georgia, with Comparison of Technics," *Am. J. Trop. Med. & Hyg.* 3:615-620 (July) 1954.

Four hundred ambulatory patients in medical wards of Lawson Veterans Administration Hospital were examined for the presence of *Endamoeba histolytica* and other intestinal parasites. An average of 2.6 post-cathartic specimens per patient was examined by direct wet mounts, Ritchie formalin-ether sedimentation procedure and PVA-fixative technic. Cultivation was used on specimens from 374 of the patients. Thirty-seven (9.3 per cent) patients were found to be infected with *E. histolytica*. This rate is within the usually accepted range for the incidence of *E. histolytica* in the general population of the United States. Four of 37 (10.8 per cent) were considered to have clinical amebiasis. Two of the four amebiasis cases could conceivably have been service connected.

Comparison of technics performed demonstrated desirability of examining permanently-stained smears for amebic infections. The PVA-fixative technic provides a convenient method of collecting specimens for preparation of stained smears. This technic, which is particularly effective for amebic trophozoites, should be used in conjunction with other concentrations which are more effective in recovery and identification of cysts.

A significant relationship between presence of *E. histolytica* infections and outside toilet facilities was demonstrated. This correlation apparently was not related to rural residence of the patients.

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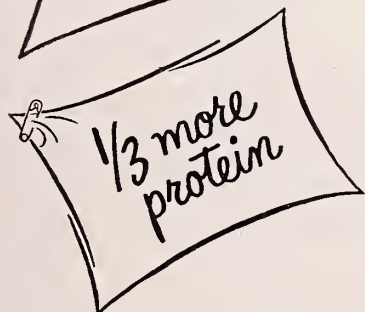
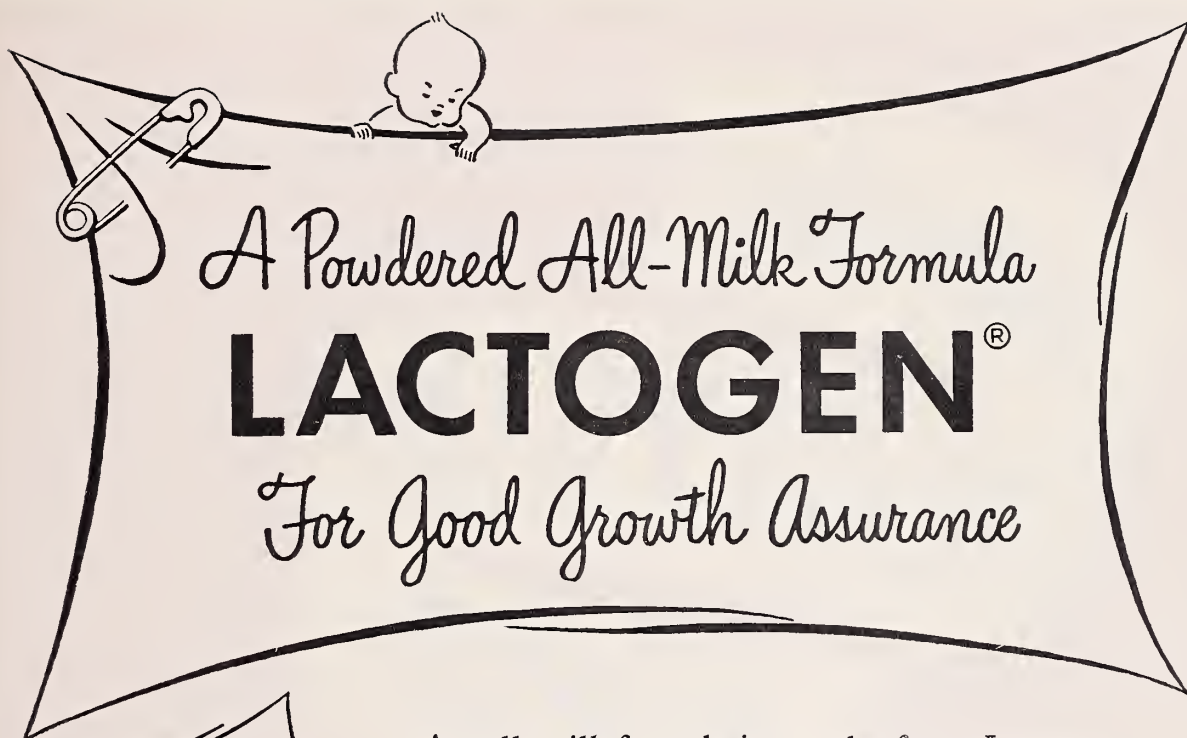
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Sesquicentennial Celebration

DOCTORS OF Savannah and Chatham County are proudly pointing to October 12th and 13th with mixed feelings of satisfied accomplishment and determined resolution. Those two days have been set aside to commemorate the founding of the Georgia Medical Society 150 years ago.

A sesquicentennial celebration is naturally the time and the occasion to cast one's thoughts in the direction of bygone yesterdays as well as to project one's thinking toward the horizons of tomorrow. It is in this spirit that the doctors of Savannah and Chatham County approach this event both with a feeling of satisfied accomplishment of a job well done and determined resolution that their profession and their organization will continue to merit the high esteem and respect of the people among whom they live and whom they serve.

The Georgia Medical Society has grown, thrived and prospered as have the people and the community which it has served, and the success of both are harmoniously interrelated. When a small group of doctors organized the Georgia Medical Society in 1804, Savannah was a small port city of 5,000 people. In the 150 years that have elapsed, Savannah has grown into a metropolitan city of 150,000 people, and the Georgia Medical Society, into a membership of 135 doctors.

No history of Savannah and the surrounding region could be written without due regard for the role of the members of this society. From among the ranks of its members have come some of the greatest names in Georgia medicine. The members of this society have striven continually, individually and as a group, to improve the stand-

ards of medical care and service to the people of their community, because they have been inspired by the belief that healthy people make for healthy, happy and prosperous communities. This society has served its people in time of war and crisis and in time of peace. Its members ministered to the gallant Confederate soldiers who withstood General Sherman's assault for eight days although they were outnumbered more than three to one. Its members served their country all over the world in World War I and World War II.

The moving spirit of the Georgia Medical Society throughout its long and illustrious history has been the attitude on the part of its members that their profession was one in the nature of a public trust which required the highest standards on their part to continue to merit public confidence. It was this spirit which prompted this society to support and crusade for an additional hospital for the region. This will materialize as the 300 bed Memorial Hospital now under construction. It was this same spirit of service that caused the society to organize last spring a highly successful series of open public forums in which physician panel members discussed medical problems with the people of the community.

While the Georgia Medical Society thus proudly looks in retrospect on its accomplishments, it also looks to the future on its forthcoming 150th birthday with the firm resolution to continue to serve the needs of its community to the best of its ability. The members of the society feel deeply that only in this manner can they live up to their heritage from the past and to the highest ideals of their profession.

L. M. FREEDMAN, M.D.

President, Georgia Medical Society

Is Amebiasis Decreasing?

WE ARE ALL familiar with the zealous work of Colonel Craig who observed that 10-20 per cent of the general population of this country harbour amebic parasites. However, a recent editorial,¹ in which a series of questionnaires

from most of the states were reviewed, showed the incidence of only 3.9 per cent of parasitization with *endamoeba histolytica* in the United States. Many clinicians contend that this divergence of opinion as to the incidence of amebiasis

is because some cases of clinical amebiasis are not being diagnosed at this time. Furthermore, it is their considered opinion that a fairly large per cent of diagnosed cases is being mismanaged from the public health standpoint.

The source of infection of most of the new cases in this country continues to be a mystery. It is felt by most investigators, however, that the impression originally expressed by Craig,² that food handlers are responsible for most of the cases, is very sound. Support is lent to this concept by the fact that the source of infection in nearly all children in whom the diagnosis of amebiasis is made can be traced to one or both parents.

The diagnosis of amebiasis can be made in a large percentage of cases if each clinician will perform a thorough work-up in all suspects. This work-up should include a good history, careful physical examination, sigmoidoscopic examination with examination of mucosal aspirate and at least three stool examinations for parasites, using either the hematoxylin (fixed) or iodine (wet) preparations. Fresh culture media should be available for planting all stools as soon as possible after collection. In patients where extra-intestinal amebiasis is suspected, as in abscess of the liver, ameboma or lung abscess, a therapeutic test will facilitate the diagnosis in all cases.

The typical picture of amebiasis as described in the text book is unfortunately not present in all active cases. When the typical picture is present it is easy to classify the patient according to the following clinical types: (a) acute ulcerative colitis, (b) acute non-ulcerative colitis, (c) chronic colitis and (d) cyst passer.

The symptoms noted in nearly every case of amebiasis include the following:

1. Fatigue which may be more evident in the morning on arising or fatigue that increases as the day passes.
2. Recurrent headaches which are usually frontal in nature or those lasting three to nine days.
3. Generalized joint aches and pains that are often diagnosed as fibrositis.
4. Nervousness of mild or moderate degree.
5. A low-grade afternoon fever averaging 100°F.

The treatment of acute ulcerative colitis should include at least two and preferably three anti-amebic drugs. The choice of these drugs should be left to the clinician treating the case inasmuch as there is no universal agreement on the best

drug or combination of drugs. Usually best results are obtained when a drug which acts on and penetrates the tissues, such as chloroquine, is used in combination with one or two drugs that act on the intestinal contents, such as terramycin, milibis or dodoquin. The most effective treatment is a 30 day course of therapy arranged as follows:

1. Chloroquine—300 mgm. per day for the first 10 days.
2. Terramycin—250 mg. Q.I.D. for the second 10 days.
3. Diodoquin—0.63 gms. T.I.D. for the third 10 days.

This treatment may be carried out on an ambulatory basis in nearly all cases. The treatment of extra-intestinal types of amebiasis requires more intensive therapy with chloroquine, while those cases of subacute and chronic amebiasis with few or no symptoms usually require anti-amebic drugs that act mainly on the intestinal contents. A new drug, fumagillin³, an antibiotic that presumably acts directly on the endamoeba histolytica organism, has been quite effective in eradicating this infection.

All patients that are treated for amebiasis should be followed for a period of at least six months. An attempt should be made to determine the source of infection. The criteria for cure should include sigmoidoscopy with microscopic examination of the mucosal aspirate as soon as possible. The persistence of diarrhea following treatment should not be alarming to the physician or the patient inasmuch as Davis,⁴ as well as many other clinicians, have observed that this may occur in at least 25 per cent of patients.

In summary, it should be pointed out that the incidence of amebiasis is apparently decreasing. It is felt, however, that there are cases of amebiasis that are not being diagnosed in some areas of the country. It should be emphasized that all patients suspected of having a new or re-infection type of amebiasis should receive a thorough clinical work-up as promptly as possible.

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Better Teamwork

In Medical Insurance

PRACTICING PHYSICIANS are becoming increasingly aware of the part played by insurance in their day to day work. The number of patients who come into the doctor's office with some type of medical fee and sickness benefit insurance has already passed the 50 per cent mark. In many metropolitan areas 75 per cent to 80 per cent of all patients seen have insurance. An investigation into this aspect of medical practice indicates that some dissatisfaction exists on the part of the patient, the doctor and the insurance company. When the cause of this discontent is more closely examined one common denominator seems to appear. This is the lack of teamwork between the medical profession and the insurance companies.

Doctors feel that the insurance forms are cumbersome and that companies will frequently do everything possible to avoid paying a justifiable claim. There is abundant evidence to support the claim that patients do not understand the type of insurance they have. They feel that their insurance does not cover what they thought it covered, and that it does not pay the amount of money they thought it would. Finally the insurance companies feel that they are treading on thin ice, because they have not been able to have frank discussions with members of the medical profession. When urged they will admit that they cannot write the type of medical coverage which they desire because they cannot be certain that it will be administered properly by the medical profession and that fair fees and reports will be rendered. When one considers the importance of insurance in medical practice today, it seems that these relatively minor flaws could be settled by better teamwork. Insurance companies should have more confidence in doctors, because we play such a large part in administering medical benefit insurance. If these two parties could settle their minor differences, the patient would of course benefit maximally.

Just such discussions as these are now being carried out in an effort to improve and expand the coverage under the "Georgia Plan." The major objections which have been brought up

against the Georgia Plan are the limitation of coverage and the definition of service benefits. There have been numerous complaints by the profession that patients who demand service benefits are not qualified to receive them. The insurance companies tell us that in order to abolish the service benefits, the entire program would have to be responsored and resold. This would be a very expensive proposition, and the outcome would be dubious. An effort is now being made to plug up some of the loopholes in the Georgia Plan, to better define service benefits and to upgrade the scale of fees allowed under the policy. This is a difficult and time consuming task. It cannot be hoped that there will be any immediate change within the next few months. However, it is hoped that within the next year a program will be outlined which is superior to our present plan.

Deductible Insurance

In this regard, there is another and entirely different approach to the whole problem of medical fee insurance coverage. Various men in the insurance field, and some members of the medical profession, think that a better policy would be one which did not attempt to include service benefits, but would be a 50 to 100 dollar deductible policy. Above this point, the insurance would cover medical fees up to, and including, a specified limit. Many insurance men feel that this type of policy would eliminate much of the petty detail and misunderstanding which are inherent in the service type program. However, companies are reluctant to write such coverage because they have not been able to obtain from the medical profession any standard and fair schedule of fees. There are instances where exceedingly high fees have been charged when a large amount of insurance is in force. Such practice would obviously destroy any type of catastrophe insurance, which this latter plan is called. What the final answer will be, is not yet entirely clear, but it is certain that members of the medical profession, and members of the insurance profession, must come closer together in order to establish the mutual understanding which will be necessary to promote insurance on a private enterprise basis. If we as

members of the medical profession take an aggressive and understanding attitude in this regard, we will have our best guarantee against federal control of the medical practice.

Malpractice Insurance

The doctors in Georgia have a recent and active interest in another aspect of insurance, namely, Professional Liability Insurance. As we all know, there has been a recent 100 per cent increase in the already high premiums being paid for this type of coverage. Companies are quick to tell us that their experience, and losses paid, well justify this increase. However, an investigation into the number of malpractice suits lost over the state would indicate that the administration of this type of insurance leaves something to be desired. True, a great deal of money has been paid out on malpractice claims; most of these represent settlements out of court. Those cases which have been fought in court, particularly among the

doctors who did not have insurance, have indicated that there are few verdicts handed down against doctors in the course of their practice. Efforts are now being made to obtain some type of group insurance which will permit doctors in the state to get Medical Liability Insurance at a considerably reduced premium. Some interesting offers have been made, and it is believed that this insurance will be made available at a reduced rate. We must all remember that a high percentage of participation will be necessary.

In summary it would seem logical to say that the best means of solving the problems which now exist in the field of medical insurance is better teamwork. Such teamwork is already beginning to bear fruit. These teams are composed of practicing physicians and insurance company executives. The better the insurance coverage, the happier will be our patients. This will be a strong support for the private practice of medicine.

General Practitioners Plan Sixth Annual Session

OF SIGNIFICANCE this month is the Sixth Annual Session of the Georgia Academy of General Practice scheduled for October 20-21 at the Atlanta Biltmore. Fourteen outstanding guest speakers will present papers at this two day session. Subjects covered include pediatrics, cardiology, neurology, obstetrics, dermatology, urology, radiology and internal medicine. These papers are prepared for delivery to general practitioners, and the GAGP program committee has designed the program to cover a wide range of topics with brevity and clarity.

On the social side, the Academy has booked exclusively the "Ice Show" for the GAGP Banquet the evening of October 20. Mix a good scientific session with top notch meals, entertainment and 200 to 300 Georgia general practitioners, and you have a really great annual meeting to attend.

About one-third of the general practitioners in the state of Georgia are official members of the GAGP. Membership in the Academy is increasing as its aims are becoming known. According

to an article in the Academy's publication *Georgia General Practitioner* entitled: "Why Should I Join the GAGP?" by Editor Peter Hydrick, M.D., "The purpose of the Academy is to improve standards and quality in general practice among the general practitioners of Georgia.

"Once organized with sufficient numbers, the Academy can carry out its objectives which are to maintain and promote a high standard of practice of medicine and surgery; to encourage and assist young men and women in preparing and qualifying themselves for general practice; to preserve the right of the general practitioner to engage in the medical and surgical procedures for which he is qualified by experience and training; to assist in providing postgraduate training study courses for general practitioners."

Certainly then the activity of this organization is important to Georgia medicine. The members of the Medical Association of Georgia can render great service to the profession-at-large, and their own Association through their support of the Georgia Academy of General Practice.

The Georgia Medical Society

1804-1954

PETER L. SCARDINO, M.D., Savannah, Ga.

SIR WILLIAM OSLER stated in his centennial address before the New Haven Medical Society that the educational value of a medical society was perhaps the most important of its many functions. When the Sesquicentennial of the Georgia Medical Society passes in review, one immediately feels that the driving force of its founders and those outstanding physicians of a century and a half ago was a deep seated desire to

improve the educational status of the medical community. Knowing "that the killing vice of the young doctor is intellectual laziness" the society sought to guard against this by the founding of a medical library. This library was begun in 1807 and has progressed uninterruptedly. While it suffers from the lack of permanent housing facilities, the purchase of journals and medical books continues. These are used increasingly by authors



Seated left to right: Jabez Jones, oldest member of society; L. M. Freedman, president; Lee Howard, Sr., chairman of board of Trustees. Standing left to right: W. W. Osborne, secretary; T. A. Peterson, vice-president; R. O. Bowden, treasurer.

in the preparation of scientific articles and are temporarily housed in the Savannah Public Library Building.

It is hardly necessary to review the early history of the Georgia Medical Society. It has been ably written by Anne McH. Hopkins and other prominent historians interested in the second oldest city medical society in the United States which is still active. However, certain highlights of the society's history are of interest at this time. In 1853, a group of Savannah physicians activated the Savannah Medical College which had been chartered in 1838. Their interest in better educational facilities was indicated by the fact that they pledged themselves to erect a building and to provide all necessary apparatus. There was some opposition by a few obstructive members of the society, but a fund of \$40,000 was raised and a building erected on what is now the site of the St. Joseph's Hospital. This school continued in existence for almost 30 years.

Following this period a lull in medical education set in, and, except for an occasional stimulus by a handful of scientifically minded men, little progress was made. This listlessness was further aggravated by dissension among the members which finally led to the formation of a second medical society. The dignity and usefulness of the profession was marred for several years by this schism which resulted from the acrimony between the older men and the younger. The society should be the professional cement, and such did it eventually become through the efforts of understanding men of both groups. The breach was healed, but that which initiated the difficulties is reflected in the problems of today.

In the community there are numerous small hospitals. None of these institutions has been large enough to provide the physician with the tools he requires to work as effectively and efficiently as he might; or at least that has been the excuse given for the failure to establish a single approved training program. There has not been provided a system, until recent years, of pathological conferences and clinics worthy of the men engaged in private practice. One comes to believe that it must have been these early quarrels which deprived the community of better diagnostic and treatment facilities.

But the Georgia Medical Society after World War II found its returning and new members imbued with the burning desire to make this a scientific area of which they could be proud. At once committees were appointed to study the possi-

bilities of gaining new medical facilities and of improving those already possessed. This wave of enthusiasm spread over the society and touched the entire membership. The staffs of all the hospitals and their administrators and trustees recognized that the society would not stop until Savannah could match other communities with unexcelled medical facilities. Sixty-odd physicians, native and new, arrived after World War II to explore this medical frontier land. And much to the surprise of all, these well-trained specialists and general practitioners in a short time successfully overcame the usual obstacles and are now solidly planted in the sandy soil. They, with their older colleagues, are now witnessing a golden age of Savannah medicine. The rapid and progressive changes being made are a tribute to those early founders. Rising at this time are some 500 new hospital beds and new ancillary services, new laboratory and research facilities. And at long last at least three of the institutions will for the first time be able to institute an adequate teaching program for interns and residents. Savannah medicine is still on the march. Witness its new institutions, the changes amongst its older ones, the productivity of its outstanding practitioners, the numbers of scientific articles which its members publish, the journal clubs and the rejuvenated hospital staffs, its surgical society—reviewing these evidences of medical progress, one is pleased with its membership.

To continue its program of education and research and at the same time indulge in a bit of deserved pleasure the Georgia Medical Society will on October 12th hear Dr. W. TeLinde, Professor of Gynecology, The Johns Hopkins University, and Chief Gynecologist, Johns Hopkins Hospital, lecture on Carcinoma of the Cervix. On Wednesday evening, October 13th, the society and its guests will close the two day celebration with a banquet and dance.

Looking back 150 years with respect and awe at a heritage begun in the time of Jefferson and the Louisiana Purchase, the overall impression is one of a society's having continuity because of good will and cooperation between its members. If the best of the past can be combined with a channeling of energies toward the common goal, if the individual members can not only be unselfish for the present good, but also for the future good, then vision will be added to understanding and the next 150 years will truly be something to behold.

2515 Habersham St.

Surgical Treatment of Acquired Non-Rheumatic Heart Disease

HERMAN K. HELLERSTEIN, M.D., Cleveland, Ohio

WHILE THE SUCCESS of surgical treatment of congenital heart disease has been recognized in the past 15 years, the magnitude of the number of patients with acquired heart disease who might benefit from surgery generally is not appreciated. The successful repair of mitral stenosis in the past five years has been uniformly enjoyed by surgeons throughout the world. Since rheumatic heart disease and congenital heart disease constitute but a small percentage of all heart disease, it is highly possible that in the near future a much larger percentage of patients with heart disease will be treated by surgery. It is the purpose of this presentation to discuss the indications for surgical treatment of acquired heart disease exclusive of rheumatic aortic or mitral valvular surgery. Because of the limited time the coverage will be restricted to two fields; one, heart disease produced or aggravated by extrinsic factors and two, intrinsic heart disease.

Heart Disease Produced or Aggravated by Extrinsic Factors

The adequacy of the circulatory system may be challenged by extra-cardiac conditions which require surgical intervention. Those conditions which produce an increase in the work of the heart either by changes in the blood viscosity, blood volume, metabolic needs of the tissues or excessive stimulation of the myocardium may be obscure and escape easy recognition. Hyperthyroidism, particularly masked hyperthyroidism in the adult, is probably the most important condition. Heart failure and angina are thought to occur only in such hyperthyroid patients who have associated coronary arteriosclerosis. The metabolic demands of the body are increased, and there is a resultant

increase in cardiac output and heart work. Hyperthyroid heart disease is recognized by the presence of auricular fibrillation unassociated with valvular disease, difficulty in regulating the ventricular rate, tolerance to large doses of digitalis, paroxysmal tachycardias, decreased circulation time and increased cardiac output. It has been found that approximately 15 to 20 per cent of patients with auricular fibrillation without rheumatic heart disease have unrecognized hyperthyroidism. The treatment of the isolated adenoma is generally accepted to be surgical. Diffuse enlargement of the thyroid can be treated by chemo-surgery performed by the use of radio-active iodine. The response to such therapy is dramatic. In the majority of patients auricular fibrillation has been converted to regular sinus rhythm post-operatively.

Fistulas between the arterial and venous systems likewise can produce cardiac symptoms by an increase of heart work. Traumatic fistulas often occur after penetrating or non-penetrating wounds in conspicuous or occult positions. The presence of venous hums, increased cardiac output, heart failure, increased blood volume and other manifestations of high output failure are noted. These patients are readily cured, and the cardiac manifestations are completely reversible.

Patients with hyperinsulinism often present themselves with predominant cardiac symptoms. Hyperinsulinism should be suspected if a patient has anginal seizures associated with tachycardia, tremors, sweating and occasionally syncope approximately four or five hours after meals. The location of the islet cell tumor in the pancreas and its complete resection are followed invariably by relief of the symptoms of hyperinsulinism. Similarly the heart may be stressed by increased amounts of circulating epinephrine produced by a pheochromocytoma. The predominant manifestation may be that of intermittent or persistent

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Presented at the Fifth Annual Meeting of The Georgia Heart Association, September 5, 1953.

severe hypertensive cardiovascular disease associated with other symptoms of periodic outpouring of epinephrine. The appearance of heart failure and particularly angina in patients with chronic severe or acute anemias warrants an investigation of the underlying cause of the anemia. Often the source is in the gastro-intestinal tract, and surgery may be indicated.

Intrinsic Heart Disease

Aneurysm of the Aorta and Great Vessels.

Aneurysm of the aorta may now be successfully resected in selected cases. The incidence of syphilitic aneurysm has decreased in recent years, but currently there are still sufficient cases to consider surgery in selected instances. Resection of the aneurysm is indicated if compression of vital structures, particularly the trachea, or dysfunction of other organs is produced by an aneurysm that is increasing in size. Two years ago Dr. Claude Beck successfully resected a luetic aneurysm of the innominate artery which had been producing life—endangering tracheal obstruction. The neck of the saccular aneurysm was isolated, and a primary resection was performed. The lumen of the innominate artery was restored without a vein or arterial graft. Occasionally it may be necessary to resect the aneurysm and the adjacent wall and to restore the continuity of the aorta by implantation of a graft. The management of thrombosis of the aorta and its branches is beyond the scope of this presentation.

Pericardial Disease. Disease of the pericardium may interfere acutely or chronically with the filling of the heart and the circulation.

Acute Compression. The symptoms of an acute cardiac compression (Beck Triad) are well known but should be re-emphasized: low arterial pressure, high venous pressure and a quiet heart.¹ Other findings include decreased cardiac output and a small peripheral pulse which is often paradoxical. The area of the heart dullness is increased although precordial activity is decreased. The liver is enlarged, and free fluid is found in the pleural and peritoneal spaces. The x-ray frequently does not show the characteristic water bottle appearance although roentgenkymograms do show decreased cardiac pulsations. I have seen acute cardiac compression occur in chronic leukemia, pericardial tumor metastasis, penetrating wounds of the chest, myocardial rupture, pericarditis, nephrosis, hypothyroidism and tuberculosis. Hemopericardium secondary to anticoagulant therapy has been reported.² The symptoms

of acute cardiac compression may develop insidiously. Most frequently the symptoms are confused with those of right heart failure.

In the past two weeks I have seen patients demonstrating the importance of recognizing the insidious nature of this disease. One 45 year old patient was admitted to the University Hospitals of Cleveland because of fever, ankle edema, dyspnea and ascites. X-ray of the chest revealed pulmonary infiltration in the left upper lobe and an enlarged quiet heart without pericardial calcification. The diagnosis of acute pulmonary tuberculosis with probable tuberculous pericarditis was made. Streptomycin and other anti-tuberculosis drug therapy were instituted. Six hundred cc. of sero-sanguineous fluid was removed by pericardial tap after which the patient experienced great relief of dyspnea, and the venous pressure decreased from 32 to 16 centimeters of water. Air injected into the pericardial space revealed marked thickening of the pericardium. Within a matter of three days the fluid had re-accumulated, and the patient's symptoms underwent an exacerbation with a rise in venous pressure. In view of the recurrence of this pattern after several taps, surgical resection of the pericardium was indicated. Another patient is at present on our wards. This patient has chronic myeloid leukemia which has responded adequately to therapy. Recently typical signs of acute cardiac compression appeared. Several pericardial taps were followed by rather rapid re-accumulation of fluid and no relief of symptoms. Resection of the pericardium has been advised.

It is important to recognize that in acute cardiac compression, fluid may accumulate gradually without producing symptoms. However, an accumulation of a relatively few cubic centimeters of fluid may exceed the volume elasticity of the pericardial sac and will be followed by signs of acute cardiac compression. Emergency pericardial tap may be required. The technique of pericardial paracentesis should be familiar to all and ordinarily should be performed under electro-cardiographic control.

Chronic Compression. Chronic cardiac compression is a disease of decreasing frequency since the advent of adequate treatment of tuberculous pericarditis. The experience of the University Hospitals of Cleveland, consisting of patients operated by Dr. Claude Beck, has been recently reviewed.³ The causes of cardiac compression include tumor metastasis and chronic inflammatory processes, most commonly tuberculous although

approximately half are non-specific. Histoplasmosis has been indicted in several instances. Cardiac compression occurs in all age groups, most frequently from the third to fifth decades of life. The triad described by Dr. Claude Beck, a result of his experimental work on dogs,¹ has been verified by the analysis of our clinical data. The heart is quiet, ascites is present, and the liver is enlarged. In all cases the venous pressure is elevated, usually 25 centimeters of water or more. The heart sounds are diminished, although the area of the heart is not small. The actual cardiac muscle mass, however, is decreased secondary to disuse atrophy. Dynamic studies indicate an increased venous pressure, decreased cardiac output, a narrow pulse pressure, decreased stroke volume and increased blood volume.³ The pressure curves in the right ventricle are typical, showing a dip in the curve at the end of ventricular systole.

The diagnosis of cardiac compression is simple if suspected. The x-ray may show linear plaque-like calcification and the roentgenokymogram reveal decreased pulsations. The indication for surgical intervention consists mainly of recognition. There is a danger of waiting too long. Obtaining free fluid by pericardial tap does not contra-indicate surgery. I am familiar with several instances where surgery was not performed because free fluid was obtained, although signs of cardiac compression persisted. In such cases there is scar tissue around the superior and inferior vena cava and the atria producing the signs of cardiac compression. Surgery is definitely indicated therefore in all patients with signs of cardiac compression and especially those whose signs persist after pericardial tap.

Endocardial Disease. Tumors of the heart are rarely diagnosed clinically and therefore surgical treatment is as yet rare.⁴ Surgery is indicated if the diagnosis is made and if the lesion is dynamically significant. We have recently studied a 45 year old woman with a history of repeated pulmonary infarction and peripheral thrombo-embolism. At times she had a murmur of mitral stenosis. Upon exploration a large ball-valve tumor mass was found attached to the posterior wall of the left atrium and was intermittently blocking the mitral orifice. A clot was adherent to the tumor mass. The mitral valve was completely normal by palpation. The patient was referred to another city where a heart lung machine is available for possible resection of the tumor under direct vision. As yet the procedure has not been

done. Occasionally such patients have intermittent periods of syncope due to intermittent obstruction of the mitral orifice. The diagnosis might have been suspected before digital exploration of the heart because of the intermittency of the murmurs of mitral stenosis.

Another interesting patient seen recently emphasized the importance of diagnosis. A 48 year old woman had chief complaints of dyspnea, abdominal distention and swelling of the ankles. Previously she was admitted to another hospital because of fatigue, non-productive cough and slight dyspnea of six months durations. Her blood pressure varied from 150/110 to 230/140. There was moderate elevation of her temperature which lasted one year. There was a grade III systolic murmur in the left third interspace, and a grade I systolic murmur at the apex. In the following three years there were four hospital admissions, each time with similar symptoms. On the first admission a pleural effusion appeared at the right base. Paracentesis revealed cloudy fluid with a specific gravity of 1.013. Microscopic studies revealed no tumor cells, and all cultures were negative. A pleural effusion subsequently appeared at the left base. Transient swelling of the left arm appeared without obvious venous thrombosis. Weakness and vertigo persisted, especially in the upright position. The following year ascites was noted and repeated paracenteses were performed. A year later the thoracic and abdominal fluids became milky due to presence of fat particles. In spite of digitalis and diuretics hydro-thorax and ascites recurred. Her blood pressure gradually fell to 100/80. A month prior to death there was swelling and induration of both arms. The serum protein was normal at first and fell to 4.2 grams with an A/G ratio of 1.5. The venous pressure was 25 centimeters. The electrocardiogram showed low voltage. A week before death serum sodium dropped to 120 milliequivalents per liter and chloride to 90 milliequivalents per liter. Death occurred after an attack of abdominal and thoracic pain. A tumor obstructing the thoracic duct was suspected. Post-mortem examination revealed a large myxoma of the right auricle which almost filled the atrium and obstructed the tricuspid orifice. The tumor was definitely operable.

Thrombosis of Chiari's network is extremely rare.⁵ This vestigial structure may become thrombosed and produce signs of inferior vena cava obstruction. A resection or removal of the network would be feasible.



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Myocardial Disease. Tumors of the myocardium and pericardium are extremely rare, but have been removed surgically because they are easily diagnosed by fluoroscopic and angiocardiographic studies.⁶ Thirteen years ago Dr. Claude Beck successfully removed a calcified tumor of the myocardium in a 39 year old man. The patient is still living and fully occupied, free of symptoms. Aneurysm of the ventricle occasionally may be helped by surgery.¹³ Usually surgery is not indicated for aneurysm of the ventricle unless there is a great loss of the force of contraction through systolic bulging of the aneurysm. The danger of rupture of old ventricular aneurysm is extremely rare unless there is a super-imposed recent infarct. The operation consists of strengthening the aneurysmal area by the local application of fascia lata.¹³ The indication for surgical repair of a ventricular aneurysm is the presence of excessive bulging of the aneurysmal area during systole demonstrated by kymograms and associated with low blood pressure, small pulse pressure and decreased systemic blood flow.

Coronary Disease. The greatest untapped reservoir of acquired heart disease in which surgery may be feasible is that of coronary artery disease. Surgery in coronary disease consists mainly of three approaches, (1) palliative to relieve pain by denervation of the heart, (2) remedial with the purpose of improving coronary circulation, and (3) to decrease the demands on the coronary circulation by lowering the basal metabolic rate.

The value of many experiments designed to improve the coronary circulation has been dependent upon a dynamic balance between the usually progressive process of arterial narrowing (stenosis and occlusion) and the process of collateral formation. The most powerful stimulus for collateral vessel development is that of local tissue anoxia, (anemia, cor pulmonale, slowly developing coronary stenosis). When the collateral circulation is insufficient, occlusion results (1) in infarction, fibrosis and myocardial necrosis, the latter often sufficient to produce congestive failure; (2) arrhythmias produced by the ectopic activity of trigger areas. An analogy has been made between areas of myocardium deprived of adequate blood supply functioning as trigger areas and ischemic areas in the brain giving rise to convulsions. It is surprising how little blood is required to flow through collateral circulation to allow the survival of heart muscle. Dog experiments have shown that an area of myocardium

supplied by multiple vessels can continue to function after the ligation of all but one vessel to this area. This small vessel would allow no more than four or five cc. of blood to flow per minute. Ligation of this last vessel invariably results in death.⁷ On the basis of flow studies by Eckstein and associates,⁸ it has been shown that the prevention of ventricular fibrillation is literally dependent upon less than one teaspoonful of blood (five cc. of blood) per minute.

The methods of increasing coronary circulation have been mainly surgical. There is little evidence as yet that heparin, nitroglycerin or weight reduction has any value in preventing the progression of arteriosclerosis or that it enhances the development of collateral circulation. The surgical methods to increase coronary flow fall in two categories, (1) to increase extra-cardiac communications, such as those produced by abrasions of the epicardium,⁹ pericardial irritants¹⁰ (talcum, asbestos) and extra-cardiac anastomoses such as those produced by anastomosis of the omentum,¹¹ of the pectoral muscles¹² and arterial blood vessels directly. The second approach has been that of increasing inter-coronary communications by (1) ligation of the coronary sinus¹⁴ (Gross), (2) pericoronary neurectomy and ligation of the coronary sinus (Fauterx)¹⁵ and (3) arterialization of the coronary sinus.¹⁶

Arterialization of the Coronary Sinus. The concept of arterialization of coronary sinus has been developed by Dr. Claude Beck and associates.

The use of the coronary venous system as an arterial system is dependent upon at least four major principles: (1) that the venous system is intact and relatively normal in patients with coronary artery disease. (2) That oxygen can be extracted by tissue if oxygenated blood is profused through the capillary bed from either the venous or arterial approach. (3) That in the myocardium adequate venous channels exist or develop to carry away the blood once it has passed through the capillary bed (to other venous channels, particularly anterior cardiac veins of the right ventricle and right atrium, to luminal or Thebesian vessels). (4) That the veins adapt readily to withstand arterial pressures. The validity of these principles has been established by the work of Beck and Eckstein and associates.

The operation of arterialization of the coronary sinus, to be referred to henceforth as the Beck operation, consists of two stages and occasionally

three. The first stage consists of placing a vein graft between the aorta and coronary sinus or a direct anastomosis between the aorta and coronary sinus. Stage two consists of narrowing of the coronary sinus orifice two or three weeks later to a size of approximately two millimeters. The purpose of this lumen is to provide an escape channel for arterialized blood which passes from the aorta to the coronary sinus, if the pressure in the coronary sinus becomes excessive. This acts as a safety valve and prevents over-engorgement of the myocardium. Stage three (performed in only three patients) consists of complete ligation of the coronary sinus at a later date. In his original description of the operation Beck anastomosed in one stage an artery to the coronary sinus and ligated the coronary sinus completely.¹⁶ Because of the high incidence of coronary sinus thrombosis and venous engorgement this operation was discontinued.

Experimental evidence of protective value of this operation against coronary occlusion: the extensive physiologic studies can be summarized in four major headings. (1) The mortality rate is low in dogs which have been protected by the Beck operation.^{17 18} It is unequivocal that dogs which have either the left anterior descending or coronary circumflex artery occluded acutely will have a 70 to 90 per cent mortality rate. In dogs prepared by arterialization of the coronary sinus, coronary occlusion will result in death from zero to 10 per cent of the cases.¹⁸ This protection is statistically significant. In our own studies we have demonstrated that in the individual dog a test vessel will regularly produce ventricular fibrillation within two to three minutes after occlusion. If the heart of such a dog is defibrillated and then the coronary sinus is arterialized the same vessel can be occluded without causing death. In other words the arterialization of the coronary sinus both in the acute and chronic dog will protect the dog against a major coronary artery occlusion. Dr. Claude Beck has ligated every available coronary artery (exclusive of the septal artery) in a series of dogs with resultant survival in such protected dogs. (2) The myocardium is protected. In the dogs protected by arterialization of the coronary sinus, the amount of myocardial damage is small or none at all, whereas in the 10 per cent of the control dogs (unprotected by coronary sinus arterialization) which survive there are large areas of myocardial infarction, often with aneurysm formation.^{16 17} (3) Back-flow studies indicate that blood gives up oxygen as it passes

through the capillary bed of the myocardium.^{17 18} Retrograde back-flow of blood from the distal end of a divided coronary vessel (the left circumflex or the left anterior descending artery) in a normal dog is about 2.5 cc. per minute. In the Beck dog the flow is approximately 7.5 cc. after the first stage and increases to 20 cc. after the second stage. This blood is venous indicating that the blood from the graft has passed through the myocardial capillary bed and that oxygen has been extracted. After several months the retrograde flow becomes arterial, and arterial collateral circulation is abundant.¹⁸ In humans an interesting phenomenon has been observed. When the coronary sinus is arterialized the coronary veins on the surface of the heart become pink and apparently indicate a true reversal of flow of blood. In the dog this occurs only if a coronary artery is occluded. On the basis of the experimental work on dogs application of this operation was made to human patients. Further experimental study is indicated to determine the long term persistence of collaterals and the duration of protection against coronary occlusion over a period of years.

Selection of cases and method of study. Because of the importance of careful selection of cases a committee was constituted to evaluate each patient. This committee consisted of Dr. Harold Feil, Dr. Joseph H. Hayman, Jr., Dr. Walter Pritchard and Dr. Herman K. Hellerstein. Each team member made separate observations and formed an opinion independently. A special resident physician supervises the details of preliminary studies, co-ordinating the medical and surgical services during the operation and during the post-operative period.

Comprehensive studies were performed to exclude other pathologic conditions which might simulate the symptoms of arteriosclerotic heart disease. Physiologic studies were performed in selected cases, including cardiac catheterization, ballistocardiograms and studies on the treadmill. The symptoms of angina pectoris were considered the most important evidence of coronary insufficiency. The emotional and social factors were carefully evaluated. All patients had conclusive evidence of coronary arteriosclerosis—history of angina pectoris, previous infarction, coronary arteriosclerosis at operation or autopsy and positive exercise tolerance tests. Over 75 per cent had previous myocardial infarcts. Every effort was made to avoid operating on patients with infarction that had occurred within the previous year.

In the first two years bad risk patients were accepted for operation; thus three patients died, one while pre-operative studies were being performed, one during a test anesthetic procedure and another during the resection of a brachial vein under local anesthesia. In general the patients in our early experience were not good candidates for the operation—the amount of myocardial damage being excessive. Finally the following criteria were established for the selection of cases: (1) progressive coronary arteriosclerosis producing functional disability, unaltered by medical therapy, (2) ages—under 60 years, (3) blood pressure less than 180/100 and (4) no congestive failure or significant cardiac enlargement. Contra-indications for operations included, (1) infarction in the past six months, (2) impending infarction, (3) congestive failure, (4) significant valvular disease, (5) severe calcification of the aorta, (6) active peptic ulcer or gall bladder disease, (7) significant myocardial enlargement, (8) ventricular aneurysm, (9) systolic blood pressure over 180 and (10) total incapacity of the patient.

In the course of the development of this operation, improvement and modification of the surgical technique, and better preparation and selection of cases have resulted in a lower operative risk and a higher yield of good results.

Pre-operative preparation included sedation, rest, nitroglycerin, if necessary, and routine pre-operative digitalization. The use of routine pre-operative digitalization in the absence of congestive failure was based upon an empirical observation made during the course of dog experiments in the resuscitation course of the Cleveland Area Heart Society. We observed that dogs which were being used for the course of instruction were able to withstand repeated periods of induced ventricular fibrillation after they had been digitalized. The validity of this observation has not yet been established clinically, although it seems to be confirmed by the lower incidence of congestive failure during and following operation in routine¹⁴ digitalized patients.

During operation close co-operation exists between the surgeon, anesthetist and the medical cardiologist. The cardiac mechanism is monitored continuously with the use of a cathode ray oscilloscope. Rest periods, re-inflation of the lungs and careful control of the blood pressure are maintained. Wyamine® and other pressor drugs in small doses have been used in over 60 per cent of the cases to control mild periods of hypotension. Great care is taken to avoid overloading the

circulatory system with excessive blood and fluid. Pronestyl® and local procaine are used to control ventricular arrhythmias. As noted previously¹⁹ many of the complications occurred before the cardiac portion of the operation—constituting the risk that thoracotomy entails in a patient with arteriosclerotic heart disease.

In the entire experience the following complications have occurred: hypotension, bundle branch block, acute congestive failure, ventricular premature beats, ventricular tachycardia, standstill and ventricular fibrillation. In the past two years the number of cardiac complications has decreased significantly, probably due to improved technique, better risk patients and possibly related to the routine pre-operative digitalization. Post-operative management is similar to that of all cardiac surgery, including oxygen therapy, prophylactic antibiotics and blood as necessary. Anti-coagulants were not administered. Some patients developed signs of congestive failure immediately post-operatively due to the large A-V fistula which had been created. These patients generally responded to mercurial diuretics and digitalis. Some of the subsequent best results occurred in these patients. Congestive failure generally disappeared after the second stage operation where the magnitude of the fistula flow was decreased. A few patients developed a hyponatremic syndrome in the first week post-operatively and responded to the administration of sodium chloride. Early ambulation was carried out in all cases. Many patients with angina decubitus were relieved post-operatively, but because of the combined effects of anesthesia, opiates, rest and psychic factors no conclusion was reached that the operation was the cause of the immediate post-operative improvement.

Analysis of results. A total of 61 patients was studied at Lakeside Hospital in the period of January 1948 to March 1953. The ages range from 35 to 65 years. All but two cases were males. In the early development of the operation as mentioned before, an arterial graft was placed between the aorta and coronary sinus, and the sinus was ligated completely. This was all done in one stage. This operation was soon abandoned because of the occurrence of thrombosis of the graft, coronary venous engorgement and hemorrhage of the myocardium and high mortality rate (three of four cases). In eight cases the operation could not be performed for technical reasons—calcific arteriosclerosis of the aorta or

excessive thinness of the coronary sinus. In these eight cases an alternative operation was performed—a previous Beck operation” consisting of pericardial abrasion, local implantation of asbestos powder and ligation of the coronary sinus. In five cases, cardiac complications occurred before the graft could be placed (one patient died while a brachial vein was being excised under local anesthesia), three patients developed fatal arrhythmias when the pericardium was open, and one patient developed transient shock during induction of anesthesia; the procedure was then discontinued. In 12 cases the first stage of the operation alone was performed; of this group, two died on the operating table and six died within the first week, of which three died within 33 days post-operatively and one died 3½ years later because of cerebral embolism. In 30 cases the two stages were performed with four deaths. Three patients had a third stage operation a year after the second. These patients had severe high output right heart failure which did not respond to medical therapy.

In this report, I will present the results of operation on 44 patients operated after the “growing pains” of the procedure had been overcome (from January 1951 to March 1953). In 10 of these 44 cases the graft could not be placed, in six because of anatomical features and in four because of death on the operating table. In the remaining 34 cases, the complete operation (first and second stages) was feasible in 26 cases; the first stage alone was performed in two cases. Six patients died before the second stage of operation. The mortality of the total 44 cases was 22.7 per cent, and in the cases in whom a graft was placed the mortality was 17.6 per cent. In the past six months Dr. Claude Beck has performed the complete two stage operation in 13 consecutive cases at another hospital with only one death. The operative mortality at present should be considered to range from 10 to 20 per cent.

A comprehensive study of the patients was made at Lakeside Hospital at six months or yearly intervals. Each member of the medical team again examined the patient individually and assessed the clinical status, taking into account emotional, occupational and social as well as organic factors. The results were graded as follows: *excellent*—complete relief of angina pectoris, no medication required, return to full occupation, no evidence of congestive failure. *Good*—slight angina, return to full or almost full occupation. *Fair*—slight to moderate angina and part time

occupation. *Unchanged*—no diminution or alteration of symptoms present before operation. *Worse*—increase of angina and congestive failure. Change in the severity of angina pectoris was determined from the clinical history and the change in nitroglycerin requirement. An attempt was also made to evaluate the effect, if any, of the operation on the occupational or working status and the patients general condition.

Patency of the graft was indicated by the presence of a continuous murmur in the left inter-scapular area and confirmed in some cases by cardiac catheterization of the right atrium. The pulse pressure in patients with patent graft was not significantly widened.

Clinical evaluation was made in 21 of 29 living cases with the two or three stage operation. (Table I). In six cases the operation had been performed too recently (six months or less), or morphine addiction was present (two cases) making evaluation impossible.

TABLE I.
Clinical Results in 21 Living Patients

Result	No. Cases	Per Cent
Excellent	10	47.6
Good	7	33.4
Fair	2	9.5
Unchanged or Worse	2	9.5

The results have been excellent or good in 81 per cent of this group irrespective of whether the graft was patent or thrombosed. This is not surprising since Eckstein and associates have shown in dogs that back flow and development of collaterals occur soon after the arterialization of the coronary sinus. Thus patients have shown good results even though they subsequently thrombose their graft. In many instances the improvement has been striking with return to full occupation and freedom of pain. Indeed some patients have extended their activity to fishing and hunting, marriage and expansion of their business enterprises.

The long term benefit of the operation can only be determined by the rate of survival, protection against future coronary occlusions and the persistence of the relief of angina pectoris. The long term survival rate of these patients will be compared with the mortality figures of non-operated patients with similar arteriosclerotic heart disease. At present only two patients with the two stage

operation have died after the post-operative recovery period. More cases would be expected on the basis of Lindgren's statistics on the mortality rate of non-operated patients with similar arteriosclerotic heart disease.²⁰ However, at present a statistical analysis of survival rate is not warranted.

Congestive heart failure of various degrees occurred in 47 per cent of the cases with patent grafts and, as mentioned previously, usually responded to mercurial diuretics and digitalis. Cardiac catheterization revealed that there was significant flow of blood through the graft into the right atrium ranging from one to eight liters. After the second stage operation, congestive failure usually subsided. In three patients the graft flow was excessive, producing severe congestive failure. Following complete ligation of the coronary sinus the congestive failure subsided. The diminution of angina pectoris which occurred after the second stage persisted after the third operation. At least three patients experienced clinical coronary occlusion in the remote post-operative course (months after the operation) and survived these assaults with no difficulty.

In summary then it would seem from analysis of the results to date that the primary purposes of the operation have been accomplished. Thus patients have been protected against death from coronary occlusion, myocardium has been protected and the coronary flow has improved as presumed by the diminution of angina pectoris.

Now that the growing pains of this operation are over and the technical and medical problems are being solved, it is hoped that this operation may be applied to a larger number of patients with coronary disease earlier in the course of the disease. With the lowering of the mortality rate it is conceivable that the operation may be indicated in the future on a prophylactic basis, to be done after the first appearance of angina pectoris. Better techniques need to be developed to determine the degree of arteriosclerosis of the coronary arteries and aorta pre-operatively and to lower the mortality rate even further.

General Summary

Surgical treatment of acquired heart disease is indicated in an increasing number of entities. The present report has dealt with acquired heart disease exclusive of rheumatic valvular disease. Surgery is indicated and is feasible in a group of conditions in which the heart disease is produced or aggravated by extrinsic factors. In hyperthyroidism, A-V fistula, hyperinsulinism, hyperadre-

nalism and in certain types of anemia, surgery may relieve the extrinsic factors which are associated with increased cardiac work and have produced signs of heart failure or coronary insufficiency. In a select number of cases, surgery is feasible in aneurysm of the aorta, ventricular aneurysm and endocardial and myocardial tumors of the heart. Diseases of the pericardium producing acute or chronic cardiac compression are properly treated by surgery with excellent results.

Various operations for the improvement of coronary circulation and arteriosclerotic heart disease have been reviewed. The operation of arterialization of the coronary sinus (Beck operation) is based upon sound physiological work. This procedure has been shown to lower the mortality rate after experimental coronary occlusion, to protect the myocardium and to increase collateral coronary flow and vasculature. The clinical results of this operation have been presented. The current mortality rate varies from 10 to 20 per cent. The degree of benefit in patients in whom the complete operation was performed was as follows: 47.6 per cent excellent result, 33.4 per cent good result, 9.5 per cent fair result and 9.5 per cent unchanged or worse. The striking clinical improvement in a large group of cases merits the extension of this operation to larger series of patients.

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Salmonella Paratyphoid in the Gallbladder

T. STERLING CLAIBORNE, M.D., Atlanta, Ga.

INFECTION IN THE biliary system with salmonella organisms has been reported several times* but is unusual enough to warrant the report of such a case.

A 37-year old woman presented herself for examination on July 16, 1953, complaining of rapid heart action and stomach trouble with a history as follows:

She was in good health until the latter part of May 1953. After a trip on which she ate unusual foods, she noted fatigue and a lack of energy and pep, and on taking her temperature she found it to be 100°. Fatigue continued and with this she had episodes of palpitation which were suggestive of paroxysmal rapid heart action. On June 10, 1953, she consulted Dr. Stuart S. Clauner in White Plains, New York (her home) who examined her carefully and found no specific abnormalities except the presence of fever—99-100°. Symptoms of fatigue and indigestion of vague type, with increasing frequency of stools, continued. On June 17, three weeks after the onset of symptoms, she was re-examined, and agglutinations were taken on the blood with a finding of a four plus reaction to paratyphoid B 1-80 dilution. She was given terramycin one gram a day for five days without change in clinical course. Then sulfadiazine was used for five days with a gradual and slight improvement. But a moderate looseness of stools persisted without let-up as did the fever. When the patient was questioned closely she admitted a little indigestion for several years. By this she meant moderate pain high in the epigastrium with no definite relation to the intake of food.

On examination the patient looked well although a little pale. Temperature was 100.4°, pulse was 112. There was slight tenderness in the right upper quadrant. No spasm was present. Laboratory studies showed blood sedimentation rate of eight mm. in one hour, hemoglobin 76, red count 4,080,000, white count 9,300, polys 62, lymphs 38. Urine was negative. Tuberculin skin

test was negative. Undulant and typhoid agglutinations were negative. Paratyphoid was not done. Two stool cultures were negative and blood culture was negative. A temperature chart showed a daily afternoon rise to 99.5°. X-ray studies were done of the gallbladder and colon, the colon being normal, but the gallbladder showed a number of large faceted stones.

On July 29, 1953, the patient was operated upon by Dr. Gus Dorrough with cholecystectomy. Sterile puncture of gallbladder was done, and the bile cultured with a pure growth of paratyphoid B salmonella resulting.

The post-operative course was good but the patient persisted with a temperature of 99.8 in the afternoons and two to four stools a day. Stool cultures were negative. Sulfathaladine had no effect and on August 10 because of persisting diarrhea she was given chloromycetin 500 mg. three times a day for five days. Following this all symptoms ceased, fever left, and she has remained well.

Discussion

In the medical literature there is considerable emphasis on the involvement of the biliary system in the course of typhoid infection. Described are cases of acute and chronic inflammation of the gallbladder and of carrier states. Also less emphasized but reported are similar cases associated with various types of salmonella. In some of these reported cases the infection has been severe and even fatal with peritonitis. Such findings suggest that it is wise to investigate the gallbladder in cases of salmonella infection of the gastro-intestinal tract and to study for salmonella in cases of cholecystitis that show unusual intestinal symptoms, especially diarrhea and persisting fever.

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Read before the Section on Internal Medicine at the 104th Annual Session of the Medical Association of Georgia, Macon, May 5, 1954.

Cat Scratch Disease

HARRY B. O'REAR, M.D., Augusta, Ga.

CAT SCRATCH DISEASE, a benign and self-limited disease whose etiologic agent has not been determined, is manifest by regional lymphadenopathy with a histological picture of reticuloendotheliosis and mild to moderate systemic symptoms.

This interesting disease has attracted considerable attention in the past four years and a number of reports have appeared in various journals.^{1 2 3 4 5} The extensive experience of Dr. Worth B. Daniels was reported in a recent issue of the *Journal of the American Medical Association*.¹

The purpose of this paper is to again call attention to its occurrence in this area and to outline methods of diagnosis.

In establishing a provisional diagnosis the following symptoms and signs, fully or in part, should be kept in mind. Almost all cases recognized to date have occurred in people who had a definite and usually intimate contact with cats.

The initial lesion, which is seen in approximately 50 per cent of the patients, appears three to seven days after the contact with the cat, usually on an unclothed area of the skin. It appears at the site of a scratch, claw penetration or at the site of a previous but still recent injury. The initial lesion may appear as (1) an inflamed scratch mark, (2) a raised purple or dusky red scar, or (3) a red papule which resembles a furuncle or insect bite. The initial lesion is usually slow to heal, responding little, if at all, to any single antibiotic or combination of antibiotics. It does, however, heal before the lymphadenopathy subsides.

The lymph node involvement follows the initial lesion by seven to 21 days. There is no lymphangitis accompanying the lymphadenopathy. The regions of nodes most often involved and in order of frequency are:

1. Axilla
2. Head and neck
3. Epitrochlear

4. Femoral
5. Others

The nodes usually enlarge rapidly, usually are quite tender at some stage of the disease, and the skin overlying the involved nodes may be erythematous. The nodes are discrete and movable until suppuration occurs.

The systemic symptoms, which begin at the time of the lymphadenopathy, are usually mild to moderate in degree and include malaise, nausea, weakness, aching, chills, headache, occasionally a rash and almost constantly a fever.

Three clinical forms of the disease have been described up to the present. They are:

1. *Regional lymphadenopathy*, the course of which has just been described.

2. *The oculoglandular syndrome of Parinaud's*.⁴ This syndrome has been attributed to a variety of etiologic agents, but in the past two years a number of cases have been reported in which there was contact with cats and the finding of a positive skin test to Cat Scratch Antigen. The oculoglandular syndrome of Parinaud's is manifest by a conjunctivitis, granulation of the lids, enlargement of the regional nodes and mild systemic symptoms. It is a self limited disease.

3. *Encephalitis*. Four cases of encephalitis during the height of Cat Scratch Disease have been reported. All have made complete recovery, but it is too early to determine if there will be any late sequelae.^{5 6}

A definitive diagnosis of Cat Scratch Disease may be made by:

1. A positive skin test
2. Histological appearance of an excised node.

The skin test which is of the tuberculin type is performed by injecting 0.1 cc. of antigen intradermally. The test is read at the end of 48 hours and is positive when there is: (1) A central erythematous papule 0.5 to 1 cm in diameter, and/or (2) An area of erythema 1.5 to six cm. in diameter.

The antigen which is used for the skin test may be made from pus aspirated from a suppurative node or from finely ground non-suppurative lymph node tissue. The material from suppurative nodes makes the most potent antigen.

From the Department of Pediatrics, Medical College of Georgia.

Read before the Joint Section of Pediatrics and Orthopedics at the 104th Annual Session of the Medical Association of Georgia, Macon, May 3, 1954.

To prepare the antigen: (1) aspirate pus or take finely ground lymph node tissue and culture for bacteria and fungi, (2) dilute 1:5 with isotonic saline, (3) heat to 56°C. for one hour on two consecutive days and (4) again test for sterility, if sterile then the antigen is ready for use.

The histological changes in lymph nodes excised from patients may be described as follows: The early lesion shows proliferation of the reticuloendothelial cells, distorted architecture and occasional giant cells. Some fibroblastic activity is seen. There is a melting away of the lymphocytes and a slight tendency to focalization. Later, there is marked focal distribution, with necrosis beginning in the centers.

In the past 12 months eight cases of Cat Scratch Disease have been recognized in patients admitted to the wards or clinics of the University Hospital. Six were children, and two were adults. All had a history of close contact with cats. Two had initial lesions in the form of inflamed scratch marks which were slow in healing. Seven had involvement of axillary nodes, and one had involvement of the cervical lymph nodes. Four had been treated for periods of three to six weeks with various antibiotics without response. One 10 year old girl had been ill for over two months. One

adult had had incision and drainage of the involved node on two occasions. All eight had positive skin test to Cat Scratch Antigen. All have now fully recovered without complications. No one antibiotic or combination of antibiotics appreciably changed the course of the disease.

Summary:

1. The symptoms and signs associated with Cat Scratch Disease have been briefly described.
2. Methods for definitive diagnosis have been outlined.
3. The method of preparation of Cat Scratch Antigen and its use in skin testing has been given.
4. Experience with eight cases of Cat Scratch Disease seen in the past 12 months has been described.

Medical College of Georgia

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1953-54 Yields Record Number of New M. D.'s

A record graduation of 6,861 physicians during the past year by our nation's medical schools has boosted the ratio to an all-time high of one physician for every 730 persons in the United States. This ratio will be lowered even more in the next few years as the number of medical graduates is expected to rise due to the continued expansion of the country's medical schools.

Today's physician population has now reached approximately 220,100. The record graduation figures were released in the 54th annual report on medical education in the United States by the American Medical Association's Council on Medical Education and Hospitals.

Highlights of the report:

- Enrollment of 28,227 is largest number of medical students in history of U. S.
- Freshman class enrollment of 7,449 also is

a record.

- More than 76 million dollars was spent during 1953-1954 for new facilities, remodeling or completion of buildings for medical instruction.
- Budgets for medical schools during 1954-1955 total more than 143 million dollars.
- 21,328 physicians did volunteer teaching without pay during the year.
- Ten new four-year schools are in construction or planning stages and will be in operation within the next few years.

The ten new four-year medical schools will be at the Universities of California, Mississippi, Miami, Missouri, Florida, West Virginia, Kentucky, North Dakota and Yeshiva University of New York and Seton Hall University. In addition, three other medical schools are being considered.

X-Ray Demonstrable Lesions in Occipital Headache

WILLIAM R. CHAMBERS, M.D., Atlanta, Ga.

WHEN THE CAUSE and treatment of occipital headaches of severe and intractable nature are being considered, bony pathology in the vicinity of the neuraxis is generally rated of slight importance. The purpose of this paper is to show that x-ray demonstrable lesions in this region may be much more frequent than is generally supposed. Moreover, such lesions may constitute a special group in which conservative therapy may be not only of no avail, but may actually be dangerous because of delay. The study consists of nine cases of lesions demonstrable on x-ray at or near the atlanto-occipital joint, whose principal and, in most cases, only symptom was that of severe, intractable headache. In fact, these cases were discovered during a study concerning the cause and treatment of severe occipital pain and constituted more than one-third of those cases considered by us to be of sufficient severity and long standing to warrant operation.

Seven of the nine cases presented were instances of basilar impression with or without other deformities. Scoville⁴ states that platybasia is more prevalent than is commonly known and presents as evidence 10 cases discovered by him in a two-year period. Poppen,³ O'Connell,² and Gustafson,¹ as well as many other authors, have presented cases discovered in their own practices which indicated that a search for these lesions would prove them to be of no great rarity. Gustafson¹ points out that severe neurological deficits are associated with long standing cases, and O'Connell² declares, "Results of the surgical treatment of basilar impression are considerably influenced by the length of the time interval between the onset of the symptoms and their attempted relief". The roentgenologist can assist the neurologist, the orthopedist and the neurosurgeon considerably in the demonstration of such a dangerous situation.

In each of the cases presented here, conservative therapy was given a thorough trial in the form of traction, cervical collar, physiotherapy, etc., without producing the slightest relief. On the

other hand, seven out of nine of these cases enjoyed a very satisfactory result on operation, while in the two unsuccessful cases the operative procedure was probably inadequate in the light of further study. This would indicate that severe occipital headache associated with a bony pathology at or about the atlanto-occipital joint might constitute a special group of cases.

Case I: A. C. D. was a 27-year-old white male who complained of severe, disabling occipital pain seeming to originate from the high cervical region and radiating into the frontal area on the right. Halter traction and cervical collar had been of no benefit. The pain had begun when the patient struck the top of his head when a moving car in which he was riding passed over a bump. The onset was immediate and the course progressive. The neurological examination was negative except that there was some limitation of motion in his neck. A hypalgesia over the dermatomes of C-2 and C-3 on the right was present. X-rays indicated a fusion of the atlas of the skull. A posterior rhizotomy of the sensory roots of C-2 and C-3 bilaterally was undertaken, and at operation a firm fusion of the atlas to the skull was discovered. Six years post-operatively, this patient remains completely relieved of his occipital pain.

Case II: J. W. B. was a 55-year-old white female who had complained of severe, progressive and now disabling headache in the occipital region for 10 years. It was associated with dizziness. It was aggravated by rotation of the head or when the head was held in a fixed position, as in watching television. The headache radiated to the frontal area on the left. Neurological examination was completely negative except for a hypalgesia of the first division of the fifth nerve on the left. It was noted that the patient carried her head tilted slightly to the right. X-rays suggested a basilar impression and fusion of the arch of the atlas to the skull. The tip of the odontoid process extended above Chamberlain's line. At operation, in ad-

dition to an arch of the atlas, which appeared definitely to be displaced upward within the rim of the foramen magnum, there was an Arnold-Chiari complex in which the tonsils of the cerebellum were herniated downward within the spinal canal; the cervical nerve root, as is often the case in this malformation, ran upward. A decompression of the foramen magnum was done, and the sensory roots of the second cervical nerve were divided bilaterally. One year after operation the patient's headache was much improved and was no longer disabling; there were only occasional periods of dizziness.

Case III: R. J. was a 25-year-old white female who, for three years, had had attacks of pain starting in the suboccipital area and radiating into the left parietal area. They were accompanied by a tickling, burning dysesthesia which was most distressing. They were worse on hyperextension of the neck. Just before the onset of these headaches, the patient had had her hair caught in an electric drill and had suffered a blow to the head. Neurological examination was essentially negative. There was tenderness over the occipital nerve and hypalgesia over the posterior parietal area of

the scalp and the C-2 and C-3 dermatomes. X-rays showed a basilar impression in that the tip of the odontoid process was definitely above Chamberlain's line as shown in Figure 1. At operation, the arch of the atlas was seen to be within the rim of the foramen magnum. A suboccipital decompression was done and the sensory roots of C-2 and C-3 were divided on the left only. One year later, this patient reported that she felt like a new person.

Case IV: J. L. C. was a 20-year-old colored male who had suffered excruciating occipital headaches for two to three months. They started in the suboccipital area on the right and radiated to the vertex and the right temple. Recently they had begun to radiate also to the left. Neurological examination was negative. X-rays suggested a basilar impression, as shown in Figure 2. At operation, fusion of the atlas to the skull, as well as an upward displacement of the atlas, was discovered. Many adhesions in this area were found and divided. In this case, a suboccipital decompression was not done, but a posterior rhizotomy of C-2 and C-3 was done bilaterally. Two years after operation, the patient reported that all of his



Figure 1

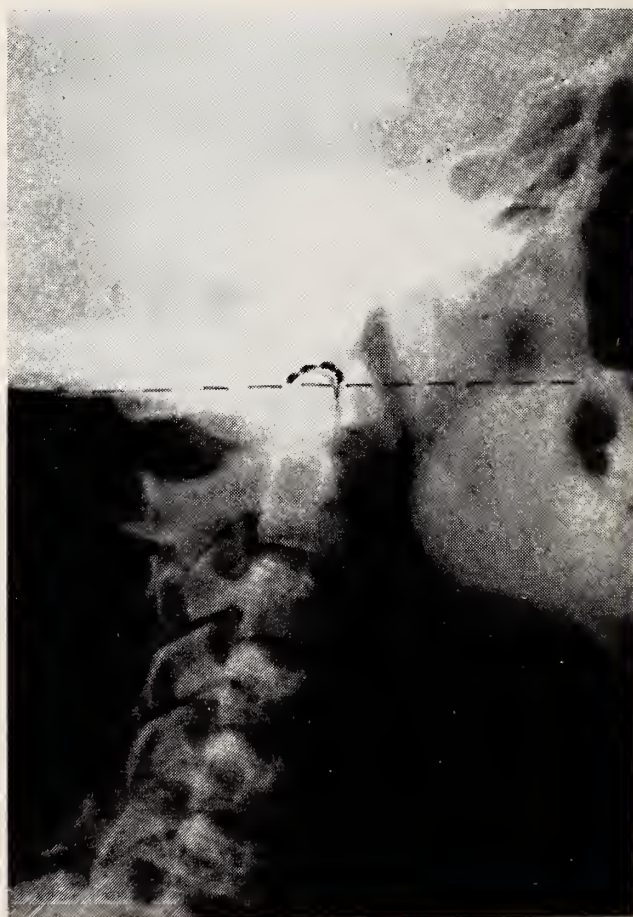


Figure 2

pain had disappeared from the time of surgery and had not returned.

Case V: L. C. was a 36-year-old female who had had occipital headache radiating down into the neck and up into the vertex for ten years. Her neurological examination was negative except that there was tenderness to pressure over both occipital nerves. When such pressure was applied, pain in the bridge of the nose developed. X-rays showed fusion of C-2 to C-3 and probably of C-1 to C-2 with a basilar impression as shown in Figure 3. At operation, these findings were confirmed. The arch of the atlas was discovered to lie well within the rim of the foramen magnum. No suboccipital decompression was done. Sensory roots of C-2 and C-3 were divided bilaterally. Eight months after operation, this patient was still quite uncomfortable. It is probable that in this case a simple cutting of the sensory roots was insufficient operation and that she might be expected to benefit from suboccipital decompression. It is also interesting to surmise that pain from the area of the foramen magnum may not be carried entirely by the second and third cervical sensory roots.



Figure 3

Case VI: L. L. B. was a 44-year-old male who had had suboccipital headaches for 10 years radiating to the vertex. The neurological examination was negative except that there was tenderness to pressure in the suboccipital area. Novocain injection of the occipital nerve gave about 60 per cent relief. X-rays in this case showed no abnormality, but, at operation, the arch of the atlas was discovered to be so high within the foramen as to be difficult to expose. No suboccipital decompression was done. A posterior rhizotomy of C-2 and C-3 was performed bilaterally. Two years after operation, this patient had experienced little relief. Again, it is felt that he might have benefited more had a suboccipital decompression been done. His x-ray is shown in Figure 4.



Figure 4

Case VII: W. F. S. was a 39-year-old male who complained bitterly of pain high in the cervical area radiating both upward into the occipital area and downward into the region of his arms and shoulders. He had numbness and clumsiness of his left arm and hand. He had a poor sense of balance. He presented himself asking whether or not he had had a stroke. On examination it was noted that he carried his head tilted forward. There was restriction of motion of the neck, a nystagmus and hypalgesia of the entire left upper extremity. X-ray demonstrated fusion of the atlas to the occiput and a basilar impression. There was a marked lordosis of the cervical spine. At operation, the x-ray findings were confirmed and, in addition, an Arnold-Chiari malformation was discovered with dense adhesions between the cerebellar tonsils and the arachnoid of the spinal cord. In this case, a suboccipital decompression was done and no rhizotomy was performed. Three years after operation, the patient reported com-

plete relief post-operatively. His x-ray findings are shown in Figure 5.



Figure 5

Case VIII: W. S., a 15-year-old female, had, in addition to distressing pain the cervico-occipital area of four years' duration, an inability to walk because of incoordination. She also complained of involuntary movements of the arms. Examination showed nystagmus with rapid component to the right, sixth nerve palsy, head tilted backward, deviation of the soft palate to the right, marked increase of all deep tendon reflexes, bilateral Babinski and a positive Romberg to the right. X-rays showed basilar impression as demonstrated in Figure 6. A suboccipital decompression was done, but no rhizotomy. Two years after the operation, she had complete relief of pain, walked well but still demonstrated mild spasticity.

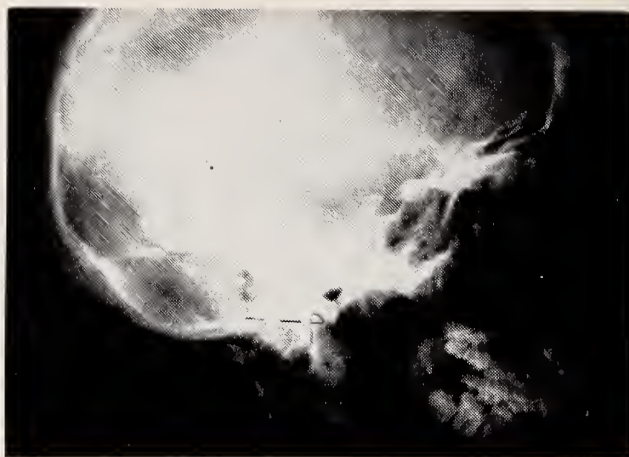


Figure 6

Case IX: H. G. S. was a 63-year-old male who had had a severe, constant bilateral suboccipital pain for five months following a fall from a ladder, sustaining a head injury. His neurological examination was essentially negative. X-rays showed a fracture of the atlas with lateral displacement of the facets. A posterior rhizotomy of C-2 was performed bilaterally. Three years later, the patient reported no relief.

Summary

Nine cases of lesions demonstrable on x-ray about the neuraxis, whose chief and only symptom was occipital headache, have been presented. Since these constituted a high percentage of the headaches of this nature which were deemed of sufficient severity to warrant surgery, it was felt significant that the occipital pain and the anomalies were associated. Such headaches did not yield to conservative therapy, but, when sufficient surgical procedure was performed, they appeared to yield well to operation. The importance of the roentgenological examination in severe, intractable occipital headache is emphasized.

101 Third St., N.E.

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Last Call for Scientific Papers to Be Read before the 105th Annual Session.
See inside back cover.

Headache and Sinusitis

JAMES T. KING, M.D., Atlanta, Ga.

MY OBJECT IS TO PRESENT the number of patients with headache that do not have sinusitis as a cause of their symptoms. There has always been a strong impression, especially by the laity, that sinus trouble is a common cause of headache, and it is sometimes difficult to change such an impression. As you know, there are literally 1,001 different causes of headache, and sinusitis is only one of them. I have been surprised not by how many headaches are caused by sinus disease, but how few. To illustrate this point I have taken from my files the records of 460 consecutive patients whose chief complaint was headache and wherein sinus trouble was either suspected or assumed. These patients were seen between 1948 and 1951. I have analyzed and grouped them according to the cause of their headache.

1. Nothing Group. One hundred seventy-three cases or 38 per cent. The first and largest group is what I have chosen to term the nothing group. In other words there was nothing about the history or from my examination that allowed the diagnosis of any disease or syndrome. Often there was nothing more apparent than that the patient was having financial difficulties. Sometimes it was that husband and wife were fighting. Some merely had hangovers. Others were just miserable and complaining about it.

2. Neuralgia Group. One hundred twenty-three cases or 27 per cent. In the second largest group are those cases with neuralgia of the various divisions of the fifth cranial nerve. This group did not differ much from the first group, the chief difference being that these patients had something a little more tangible in regard to the site of their pain. A constant finding was pain and tenderness where the affected nerve made its exit from the skull. These patients at least had some reason to suspect that they had sinusitis. When the frontal nerve was involved, in the vicinity of the frontal sinus, then the pain and tenderness of acute frontal sinusitis was simulated. And when the maxillary nerve was involved, the pain and tenderness of acute maxillary sinusitis was simulated.

3. General Systemic Group. Eighty cases or 17 per cent. In this group the patient had disease

elsewhere, such as hypertension, allergy, influenza, colds, etc., causing his headache.

4. Vascular Group. Thirty-three cases or seven per cent. Migraine 22 cases, histamine cephalgia 11 cases. In this series at least, typical migraine and histamine cephalgia were relatively rare.

5. Intracranial Disease. Nineteen cases or four per cent. Head injury 11, cerebral hemorrhage three, brain tumor two, meningitis two, multiple sclerosis one.

6. Sinusitis Group. Thirty-two cases or seven per cent. Out of every 14 patients who thought his headache was coming from his sinuses, only one actually had sinusitis.

I would like to say a few words about the treatment of patients with chronic headache who go from one doctor to another, those who have had this and that kind of treatment and have not been cured. I think it is important that we try to do something to change their attitude towards their trouble. So rather than give these patients any more histamine, vitamins, ergot derivatives and the like, I try to impart to them the simplest bit of philosophy I know, that of Mother Goose:

For every malady under the sun

There is a cure or there is none.

If there be one try to find it.

If there be none never mind it.

If these particular patients will heed this rhyme, it will help them more than any specific therapy that we have at present.

In conclusion, I would like to give a brief history of one of the most unusual cases in this series. It goes to show that things are not always what they seem, and we sometimes have to go beneath the surface to find out what is going on in these headache patients. A man came in my office with a terrible headache, his face somewhat battered and bruised. He did not however, wish his headache and contusions treated, but he wanted me to test his hearing and see if he needed a hearing aid. When I asked him "Why?" he said, "Last night my wife and I were having a little discussion, my wife said, 'Shut up', and I thought she said, 'Get up'."

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Read before the Joint Section on General Practice and EENT at the 104th Annual Session of The Medical Association of Georgia, Macon, May 4, 1954.



BOOKS RECEIVED

McAuley, W. F., *The Concept of Schizophrenia*, Philosophical Library, New York, 1954, 145 pages, \$3.75.

Poor, Russell S., *Planning Florida's Health Leadership; A Summary*, University of Florida Press, Gainesville, 1954, 93 pages, \$1.50.

Garland, Joseph, *The Physician and His Practice*, Little, Brown & Company, Boston, 1954, 270 pages, \$5.00.

Bower, Albert G., *Diagnosis and Treatment of the Acute Phase of Poliomyelitis and its Complications*, The Williams and Wilkins Company, Baltimore, 1954, 250 pages, 64 figures, \$6.50.

Florey, Sir Howard, *Lectures on General Pathology Delivered at the Sir William Dunn School of Pathology, University of Oxford*, W. B. Saunders Company, Philadelphia and London, 1954, 733 pages, illustrated, \$13.00.

Nelson, Waldo E., *Textbook of Pediatrics*, W. B. Saunders Company, Philadelphia and London, 1954, 1581 pages, 478 figures, \$15.00.

Flint, Thomas, Jr., *Emergency Treatment and Management*, W. B. Saunders Company, Philadelphia and London, 1954, 303 pages, \$5.75.

Ryan, Robert E., *Headache*, The C. V. Mosby Co., St. Louis, 1954, 338 pages, \$6.50.

Larsson, Tage and Sjoegren, Torsten; *A Methodological, Psychiatric and Statistical Study of a Large Swedish Rural Population*, Ejnar Munksgaard, Copenhagen, 1954, 250 pages.

REVIEW

PATHOLOGY IN SURGERY by Edwin F. Hirsch, Ph.D., M.D., Director of the Henry Baird Favill Laboratory and Pathologist of St. Luke's Hospital, Chicago, Ill.; Research Associate, Associate Professor (Emeritus) of the Dept. of Pathology of the University of Chicago. The Williams and Wilkins Co., Baltimore, 1953, 474 pp., 388 photographs.

It is the opinion of the reviewer that this book will prove of doubtful value to either pathologist, surgeon, resident or medical student. The outline

of the book is by organ systems and is generally satisfactory. The format is poor. The photographs are numerous and, for the most part, clear and well-labeled.

It is in the text that this book utterly fails. Readers are asked to "remember that this text is not one in either general or special pathology," but it is so sketchy as to be of absolutely no value as a reference source and of very little value for general reading. The information presented is non-specific. The bibliography is limited.

Southern Medical Association Plans Meeting

As summer has ended and school begun, arrangements for the forty-eighth annual meeting of the Southern Medical Association are about complete. The Association has met in St. Louis four times previously, 1935, 1941, 1944 and 1950. The meeting begins with a general public session on Monday forenoon, November 8. Between that time and Thursday noon, November 11, forty-eight half-day sessions will be held. During Southern Medical meetings, physicians may best associate with men whose practice is like their own, and with men in each of the other divisions or limitations of clinical work. The view-

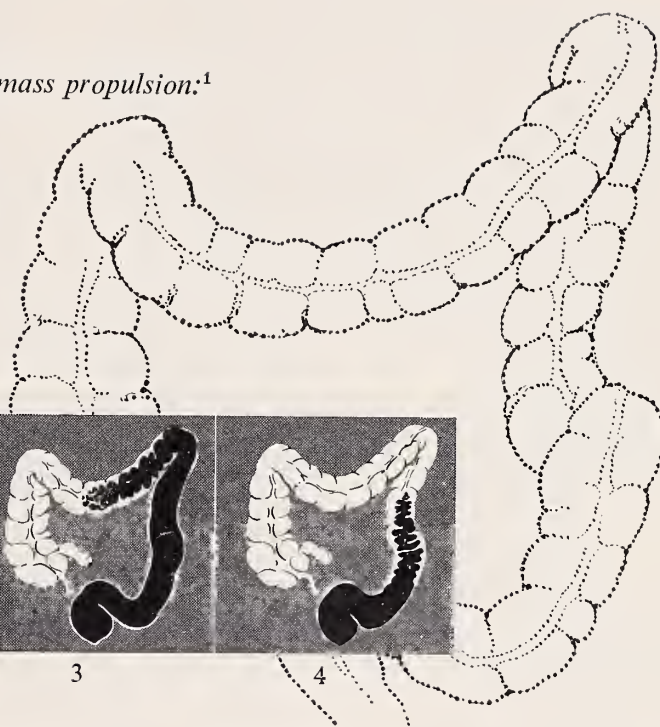
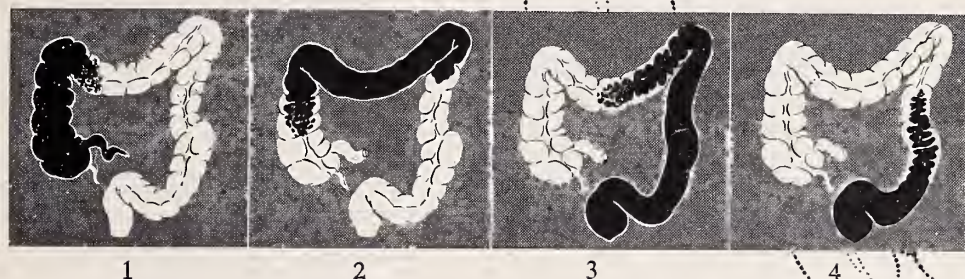
point may be broadened in any direction which one chooses. This geographical division of medicine, the Southern Medical, is large enough to attract learned men for complete coverage of the year's progress, and yet so small or so subdivided, as not to bore the personal friendliness and appreciation of individual effort which are more necessary in medical education than any textbook or physical facility.

Hotel accommodations in St. Louis are of the best. Requests for room reservations for the meeting should be sent to the Housing Bureau, Southern Medical Association, 911 Locust Street, Room 406, St. Louis 1, Missouri.

Reprinted from the Southern Medical Journal, Sept., 1954. Sept., 1954.

*Roentgenographic pattern of colon mass propulsion:*¹

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- (2) Unsegmented mass propelled through transverse colon.
- (3) Propulsive force follows mass through descending colon.
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2. Bargen, J. A.: A Method of Improving Function of the Bowel, *Gastroenterology* 13:275 (Oct.) 1949.

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AVAILABLE PHYSICIANS

Berry, Reginald V., M.D., US Naval Hospital, Pensacola, Florida, age 47, married, Protestant, graduate Yale Medical School, 1932, residency Duke University, North Carolina; U. S. Naval Medical Center, Maryland, interested in psychiatry and neurology in Georgia (clinic, assistant associate or institutional), available July-August 1954.

Coleman, Julian B., M.D., US Naval Air Facility, Weeksville, Elizabeth City, North Carolina, age 33, single, Protestant, graduate McGill University, 1952, priority 4, size of community not important, in clinic or as an assistant or associate, available July 15, 1954.

Fitz, Thomas E., M.D., 1053 Oakland Avenue, Rock Hill, South Carolina, age 32, married, 3 children, Presbyterian, graduate Duke University School of Medicine, 1949, specialty—internal medicine and cardiology presently in practice, wishes to relocate due to economic status, desires group or associate practice, available two or three weeks after location secured.

MacKavanagh, James L., M.D., 160 Marion Avenue, Marrick, L. I., New York, age 44, married, Roman Catholic, graduate Georgetown University Medical School, 1934, presently in general practice, wishes to relocate, priority 3, interested in general practice in Georgia, size of community not too important, available within two or three months after location is selected.

Taber, Richard P., M.D., Department of Pediatrics, University Hospital, Ann Arbor, Michigan, age 30, single, Presbyterian, graduate University of Rochester Medical School, 1948, residency Buffalo Children's Hospital, N. Y.; University Hospital, Michigan, priority 4, interested in pediatrics in Georgia, available July 1, 1954.

Allen, Raymond A., M.D., c/o Mayo Foundation, Rochester, Minn. Born November 6, 1921, Lyman, Utah, single, Mormon, graduate University of Louisville, 1946, assistant resident in pathology one year, New York City Hospital, Fellow in pathology three years, Mayo Foundation, interested in location in Georgia, available July, 1955.

Mackoff, Sam M., M. D., 612 W. Center Street, Lebanon, Illinois; age 39; married Synagogue; graduate University of Minnesota, 1943; Board eligible Dermatology; interested in establishing practice in clinic; available February 20, 1955.

Rozzell, Leo H., M. D., 14 Valley Street, Lewistown, Pennsylvania; age 45; married; Presbyterian; graduate University of Western Ontario, 1939; residency—St. Luke's Hospital; Priority 4F; specialty—Ophthalmology; Available August 1954.

Bragg, Rudolph, M.D., 567th Medical Squadron, McChord Air Force Base, Washington. Age 28, single, Methodist, graduate Medical College of Georgia, 1952, license held in Georgia, interested in general practice as an individual or associate,

in community under 10,000 in Georgia. Available July 1, 1954.

Kinzer, Gilbert M., Lt. MC USN, Main Dispensary, USNAS, Corpus Christi, Tex., 30 years of age, B.A. degree Vanderbilt University, M.D. degree University of Tennessee, 1947, have a basic science certificate and medical license, owned and operated a small hospital in Caraway, Ark. (GP-Surgery) took PG course in pediatrics at Harvard Postgraduate Medical School, called to active duty '51, graduated from School of Aviation Medicine, which gives special training in EENT, cardiology and physiology, desires to locate in South in a town with minimum 3,000 population, town must have hospital, plans to do general practice with obstetrics and limited major surgery, prefers an association with another doctor.

Moore, Melvin, M.D., 915 East 17th Street, Brooklyn, N. Y. Born January 5, 1924, married, Hebrew, graduate Chicago Medical School, 1946, certified by American Board of Radiology, residency, Newark Beth Israel Hospital, Queens General Hospital, specialty, Radiology, available March, 1954. York 29, N. Y., age 33, married, Protestant, graduate New York Medical College, 1954, draft exempt by previous service, interested in general practice in Georgia, available July, 1955.

Moseley, Robert W., M.D., 97th General Hospital, APO 757, c/o Postmaster, New York, N. Y., age 28, married, Christian, graduate Medical College of Virginia, 1948, residency Walter Reed Army Hospital, Board eligible for pediatrics. Available July 1, 1954.

Pattison, John D., M.D., FASRON 104 Det. 1, FPO, New York, N. Y., age 34, married, Protestant, graduate University of Pittsburgh, 1944, residency VA Hospital, service completed October 5, 1954, specialty internal medicine, clinic or group practice in Georgia, available one or two months after discharge.

Rutledge, James W., M.D., The John Gaston Hospital, Memphis, Tenn., age 29, married, Protestant, graduate New York Medical College, FFAH 1953, priority 4, served 30 months in USAAF, completing rotating internship at University of Tennessee, interested in general practice in Georgia, available July, 1954.

Schifflett, Joseph Ray, M.D., US Naval Hospital, Jacksonville, Fla., age 29, married, one child, Protestant, graduate Baylor University College of Medicine, 1953, priority 4, interested in general practice in Georgia, available August 1, 1954.

Shea, Wm. H. H., M.D., 568th USAF Dispensary, McGuire Air Force Base, Trenton, N. J., age 33, married, Roman Catholic, graduate University of Maryland, 1951, priority 4, interested in general practice, available July 15, 1954.

Stark, C. V., M.D., Box 109, Arcadia, Fla., wants practice in Georgia during spring of the year only, as he spends winters in Florida, born November 25, 1878, widower, graduate Oploma Medical University, Tenn., 1900, specialty—general medicine, population 1,000 or more.

Brannon, R. A., Jr., M.D., Vicksburg Clinic, 1600 Monroe Street, Vicksburg, Miss. Interested in establishing practice in Dermatology and Allergy at Brunswick, Georgia. Board eligible in Dermatology; had seven years experience as a health officer.

Ewing, George B., M.D., LaFargeville, New York. 50 years of age; married; Methodist; graduate Vanderbilt Medical School, 1929. Presently in practice, desires change of climate; Priority 4; interested in general practice in community of 1500 to 2000 in Georgia. Available early fall.

McCorkle, Robert G., Jr., M.D., 350 South Fuller 4J, Los Angeles, Calif. Age 30; married; Catholic; graduate Baylor University School of Medicine, 1946; priority 4; specialty—Thoracic Surgery. Interested in association with another doctor. Available August 1, 1954.

Moseley, Charles H., M.D., 707 Duncan Avenue, Killeen, Texas. Graduate Medical College of Georgia, 1952. Desires to become associated with a competent general surgeon to assist in surgery and do general practice. Available July 1, 1954.

Psimas, James M., M.D., M.O.Q. H-2, Cherry Point, North Carolina. Age 30, married, two children, Episcopal, graduate University of Virginia, 1948. Residency N. C. Baptist Hospital; St. Luke's Hospital, and DePaul Hospital. Specialty—Ob-Gyn only. Group preferred. Available September, 1954.

Henrick, James Wesley, M.D., 7030 Cohn Street, New Orleans, Louisiana. Age 30, married, Methodist, graduate University of Tulane Medical School, 1949. Will be board eligible Ob-Gyn in July, 1954. Specialty—Ob-Gyn; prefers assistant or associate. Available July 1, 1954.

Ingram, William, Jr., M.D., U.S. Naval Hospital, Oakland, Calif. Age 32. Married, Protestant, Graduate University of Georgia School of Medicine, 1946. Residency USNH, Philadelphia; St. Albans, N. Y.; Oakland, California. Specialty—Neuropsychiatry (Clinic or institutional). Available June, 1954.

Moore, George W. St. Clair, M.D., 101 Ardmoor Avenue, Danville, Pa. Age 29. Married, Protestant. Graduate of University of Pennsylvania, 1948. Residency Geisinger Memorial Hospital and Foss Clinic. Specialty—Urology. (Clinic, Assistant or Associate). Available July, 1955.

Shanahan, John Rush, M.D., 10310 Greenfield Street, Kensington, Maryland. Age 39. Married; Roman Catholic. Graduate Georgetown University, 1948. Residency U. S. Naval Hospital, Bethesda, Maryland. Priority 5. Specialty—Internal Medicine. Desires community in Georgia of 20,000 to 30,000. Available June, 1955.

Newman, Harvey, M.D., US Naval Hospital, Beaufort, S. C. Age 28; married; Protestant; graduate Medical College of Georgia, 1948. Residency Children's Medical Center, Dallas, Texas. Specialty—pediatrics. Interested in community in Georgia as associate or assistant. Available August 1954.

Woods, E. Ashby, M.D., Montevideo, Penn Laird, Virginia; graduate University

of Virginia, 1952; age 30; married, interested in obtaining a position as either an assistant or in industrial practice in Georgia.

Dodd, Patricia, M. D., (See Robert S. McDuffie) Married, one child; 33 years of age; native of Savannah; graduate University of Maryland Medical School; taken part I of the American Board of Surgery; wants location where husband and wife can practice.

Kenp, Gordon Blair, M. D., 809 S. Marshfield Avenue, Apt. 108, Chicago 12, Illinois; born October 30, 1924; married; Protestant; graduate Hahnemann Medical College, Pennsylvania, 1949; residency - Illinois Eye and Ear Infirmary; Priority 4; speciality - Ophthalmology; available July 1, 1955.

McCorvey, Norborn B., M. D., 543 Garfield Street San Francisco, California; age 34; married; Presbyterian; graduate Tulane University School of Medicine, 1944 residency, Jefferson-Hillman Hospital; 3½ years residency in Urology; Priority 4; available immediately.

McCoy, John M., (Capt. 059752), 121st Evacuation Hospital, APO 971, c/o Postmaster, San Francisco, California; age 31 married, 2 children; Presbyterian; graduate Duke University, 1947; residency - George Washington University Hospital, VA Hospital; eligible to take Part II, American Board of Internal Medicine; available March 1, 1955.

AVAILABLE LOCATIONS

Meigs, Georgia - Thomas County - one doctor's clinic available, with ample space for a two doctor set-up; one aged doctor; hospital facilities nearby; good schools; paved highways; contact: Mr. O. H. Lewis, Meigs Clinic, Inc., Meigs, Georgia.

Pearson, Georgia - Atkinson County - will furnish house and equip clinic; new Hill-Burton Hospital at Douglas guarantees staff privileges to GP; office will be rent free for six months; contact Mr. Barney Kraft, Pearson, Georgia.

Dawsonville, Georgia—(Dawson County) Have a modern well equipped health clinic. Arrangements for an office can be made without difficulty. No physician in county. (pop. 500) Contact: Mr. Carlton Gilleland, Mayor City of Dawsonville, Dawsonville, Georgia.

Doraville, Georgia (DeKalb County). Hospital in nearby Chamblee, small clinic in Doraville for rent. New homes being built \$8,950.00 up. Grammar-high school. Social and recreational facilities. Population sufficiently large enough to support physicians. (County pop. 30,900). Contact: Mr. George W. Walker, City Clerk, Doraville, Georgia.

Villa Rica, Georgia (Carroll County) New 24 bed HB hospital to be built soon. Now have seven bed hospital. Office available for lease, reasonable. Housing available at reasonable cost. 12 grade accredited school. (Pop. 3,200). Contact: Mr. Edgar P. Candler, Villa Rica, Georgia.

Buchanan, Georgia—(Haralson County) No physicians in area; 20 bed hospital, not in use, may be purchased at give

McDuffie, Robert S., M. D., US Naval Hospital, Quarters No. 1219, Quantico, Virginia; married, one child; 35 years of age; native of Atlanta; graduate Emory University School of Medicine; speciality - Ob-Gyn; want location where husband and wife can practice.

Upchurch, Kent P., 215 Pine Valley Road, Winston-Salem, N. C.; age 30; married; Protestant; graduate Bowman Gray School of Medicine, 1946; Board qualified in Ob and Gyn; interested in group practice or woman's clinic as an assistant or associate; available September 1, 1954.

Suelling, John M., Jr., M. D., 1506 Waverly Avenue; Charlotte, N. C. Born in Augusta, Georgia; graduated from Medical College of Georgia, 1943; in June 1953 completed a four year residency in general surgery at Youngstown Hospital, Ohio; prefer solo practice, but would consider an association; Board eligible; if necessary could do some general practice to get started; now available.

Sullivan, Francis Simon, 4368 Carnegie Street, Wayne, Michigan; age 29; married Presbyterian; graduate University of Virginia, 1949; residency - Wayne County General Hospital; 3 years residency in internal medicine; priority 4F; specialty internal medicine; available October 1954.

Berry, Bradley D., M.D., Whitfield, Mississippi; graduate Jefferson Medical College, Philadelphia, Pennsylvania; com-

pleted internship; interested in general practice in Georgia.

Crupie, Joseph E., M.D., 347 Plant Street, Apt. 4-F, Tampa, Florida; age 30; married; graduate University of Tennessee School of Medicine; 1953; Priority IV; interested in general practice in Georgia; available 1st wk in February 1955.

Frerichs, Cletus T., M.D., 1221 Sixth Avenue, S.E., Rochester, Minnesota; age 30; married, two children; Lutheran; graduate University of Nebraska School of Medicine, 1947; 3 year fellowship in internal medicine at the Mayo Foundation; specialty—internal medicine; prefers community of 15,000 up; available January 1, 1955.

Stewart, Lena M., M.D., 250 N. Ottawa Street, Joliet, Illinois; age 65; single, Methodist; graduate Chicago College of Medicine and Surgery; 1917; residency—Deaconess Hospital; presently in practice, desires a milder climate; interested in general practice for girls school or student health; available November 1, 1954.

Watson, Alfred Lawrence, M.D., 1415 Titus Road, Memphis 11, Tennessee; age 29; married; Methodist; graduate Vanderbilt University School of Medicine, 1949; residency—2 years at Grady Hospital, Atlanta in internal medicine and at Kennedy Veterans Hospital, Tennessee; Priority IV; specialty internal medicine; prefers clinic, assistant or associate; available July 1, 1955.

away price. Housing available rent or buy reasonably. Need two doctors to run hospital or clinic, as they so desire. Contact: Mr. P. G. Camp, Buchanan, Ga.

Marietta, Georgia—Cobb County—Interested in Negro physician to replace present physician who is going into armed forces. Contact Mr. Millard L. Wear, Administrator; City of Marietta Hospital Authority; Kennestone Hospital, Marietta, Georgia.

Roberta, Georgia—Crawford County—No physician in-area, county maintains a large home with most reasonable rental available for resident doctor. Plans for clinic nearing completion, immediate use of rooms in present clinic building, also three rooms over post office ready for use, year's rent free. Excellent opportunity for qualified physician looking for general practice. Contact Mr. J. Welborn Johnson, P. O. Box 143, Roberta, Georgia.

Arlington, Georgia—Calhoun County—In need of a doctor-surgeon for practice in new excellently equipped 161 bed hospital located to serve Calhoun, Baker, Early and Clay counties. Office space and home available. Contact: Mr. Carter Ray, Arlington, Georgia. (Population 1,382).

Attapulgus, Georgia—Decatur County—Present doctor unable to practice on full scale; has clinic with waiting rooms for white and colored patients, x-ray, cardiology, metabolism, pneumothorax, violet ray and laboratory equipment. Town is centrally located with access to hospitals. Present doctor will reserve working space in the clinic, will sell outright or lease the clinic at very nominal figure. Contact: Dr. Carl B. Welch, Attapulgus, Georgia. (Population 800).

Bremen, Georgia—Haralson County—Need an associate in field of obstetrics and gynecology. Completing a modern office building to house the group and about October 1st new 29 bed hospital should be in operation. Group consists of three physicians—2 in surgery and 1 in medicine and anesthesia. Would have all the work he could handle in ob and gyn. Contact: Dr. J. H. Pritchett, Jr., Bremen Hospital, Bremen, Georgia. (Population 3,500).

Jeffersonville, Georgia—Twiggs County—Only doctor in county is in his 70's and has been doing limited practice. Contact Mr. H. C. Swearingen, Jeffersonville, Georgia. (Population 1,000).

Woodbine, Georgia—Camden County—Small fully equipped and stocked office and clinic immediately available; ample office space, delivery room, laboratory (including x-ray), nursery, wards and private rooms; can be used as office, clinic or small hospital; 5 room wooden dwelling adjoins to hospital, available at \$35.00 per month or other houses for rent or sale; one other doctor in Woodbine. Doctor is needed now. Contact: Dr. Sam C. Atkinson, Waverly, Georgia. (Population 1,000).

When a location has been filled please contact headquarters office, Medical Association of Georgia, 875 W. Peachtree St., N. E., Atlanta, Ga.

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Amos Christie, M.D., Vanderbilt University
J. Edwin Wood, M.D., University of Virginia
W. B. Hildebrand, M.D., AAGP President
Angus McBryde, M.D., Duke University
Thomas Findley, M.D., Augusta, Ga.

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ANNOUNCEMENTS

The Ponce de Leon Eye, Ear Nose and Throat Infirmary, Atlanta, affiliated with the national Eye Bank for Sight Restoration, Inc., is offering its services for those who wish to donate their eyes to the eye bank at time of death. Physicians may obtain the necessary forms from the infirmary, which will make all arrangements after notification by the physician.

Fellowships for Basic Research in Arthritis—(1) Predoctoral fellowships ranging from \$1,500 to \$3,000 per annum, (2) Postdoctoral fellowships ranging from \$4,000 to \$6,000 per annum and (3) Senior fellowships for more experienced investigators will carry an award of \$6,000 to \$7,500 per annum. Deadline for applications is October 15, 1954. For information and application forms address the Medical Director, The Arthritis and Rheumatism Foundation, 23 West 45th St., New York 36, N. Y.

Van Meter Prize Award—The American Goiter Association offers \$300.00 and two honorable mentions for the best essays submitted concerning original work on problems related to the thyroid gland. The award will be made in April 1955; entrance deadline is January 15, 1955. For further information write to the Secretary, John S. McClintock, M.D., 149½ Washington Ave., Albany, N. Y.

SOCIETIES

The NINTH DISTRICT MEDICAL SOCIETY met on Wednesday, September 15th at 2:30 p.m. in Winder. The following scientific papers were read: Charles Skelton, Winder; Rafe Banks, Jr., Gainesville; F. M. McElhannon, Winder; and John H. Reed, Gainesville. A social hour following the meeting was held at the home of Dr. and Mrs. Alex B. Russell with dinner at the American Legion Dining Room.

Courses

Course in Hematology: Nov. 18-20, 1954, presented by the Department of Medicine of the University of Florida in cooperation with the Florida Medical Association. Course to be presented by Dr. William Dameshek, Director of the Blood Research Laboratory, New England Center Hospital, Boston, Mass., his assistant, Dr. J. Komninos, and Dr. James N. Patterson, Tampa, Fla. There will be a \$25.00 registration fee. Further information can be secured by writing the Dept. of Medicine, Univ. of Florida, 1625 Riverside Ave., Jacksonville, Fla.

Meetings

40th Annual Clinical Congress of the American College of Surgeons—Atlantic City, N. J., November 15 to 19. Guest speakers include Dr. Alan Gregg, New York, and Dr. Robert H. Kennedy, New York. For further information write to the American College of Surgeons, 40 East Erie Street, Chicago 11, Ill.

American Congress on Obstetrics and Gynecology—Palmer House, Chicago, Ill., December 13-17, 1954. For information write to the Sixth American Congress on Obstetrics and Gynecology, 116 South Michigan Ave., Chicago 3, Ill.

Georgia Pediatric Society—Mayfair Club, Atlanta, October 28, 1954. Speakers: Dr. Margaret Smith, Dr. Benj. M. Kagan, Dr. Chas. A. Janeway. For further information, contact Dr. C. Dixon Fowler, 27 Eighth St., N. E., Atlanta.

The TENTH DISTRICT MEDICAL SOCIETY held its annual meeting in Madison on August 19. Guest speakers at the meeting were Thomas Goodwin, Atlanta, who spoke on "Fractures"; R. C. Majors, Augusta, who spoke on "Pulmonary Infections"; H. M. Davison, Atlanta, whose topic was "Allergy"; and E. R. Pund, President of the Medical College of Georgia. The Woman's Auxiliary of the society also met on that date.

The WARE COUNTY MEDICAL SOCIETY met August 5th at the Hotel Ware. Hosts for the meeting were M. T. McGoogan and J. F. Hooker.

DEATHS

KATHERINE RICHARDS COLLINS, Quitman, 91, died August 10, 1954, at the Presbyterian Home in Quitman after a brief illness.

Dr. Collins is a native of New Albany, Ind.; she graduated from the medical school of the University of Michigan, Ann Arbor, Mich., in 1893. She practiced in Atlanta from 1894 to 1902 at which time she went to New York to work with the Department of Public Health. Dr. Collins occupied this position until 1908, then did research work in Buffalo, N. Y., and Savannah, Ga. Dr. Collins retired in 1930.

Dr. Collins moved to Turnerville some years ago to live with her sister. For the last four years she has lived at the Presbyterian Home in Quitman. Graveside services were held August 12 in the Mt. Zion Baptist Church Cemetery.

DAVID BITTLE HAWKINS, Atlanta, 68, died at his home August 9, 1954. He had been in declining health for some time.

Born in Virginia, Dr. Hawkins had practiced medicine in Atlanta since World War I, when he served in the Medical Corps.

Dr. Hawkins was a member of the Lutheran Church of the Redeemer.

LEWIE HUDSON MUSE, Atlanta, 63, died August 22, 1954, in a private hospital. He lived at 944 Williams Mill Road, N. E.

Dr. Muse, a native Atlantan, was a graduate of the Atlanta College of Surgeons in 1913, and he served his internship at Kings County Hospital, N. Y.

He was a member of the Druid Hills Methodist Church, the Kiwanis Club and the Yaarab Temple of the Shrine.

Dr. Muse was president of the staff of Georgia Baptist Hospital, chief of pediatrics at Crawford Long Hospital and an active staff member of the Emory University Hospital. He was director of child service for the Georgia Civil Defense Administration and a member of the Executive Board of Governors of the Georgia Military Academy. Dr. Muse was a fellow and former state chairman of the American Academy of Pediatricians, member of the American Board of Pediatricians and former chief of the Georgia Pediatrics Society.

Funeral services were held August 24 at Spring Hill in Atlanta; burial was in Westview Cemetery.

PERSONALS

H. L. BARKER, Carrollton, was entertained at a surprise birthday dinner given by his wife on the occasion of his 70th birthday, August 3, 1954. Dr. Barker has been active in the practice of medicine for 42 years, and has, in addition to practicing medicine in Carrollton, been active in many civic enterprises. He is an outstanding member of the Lions Club, having served as an International Director.

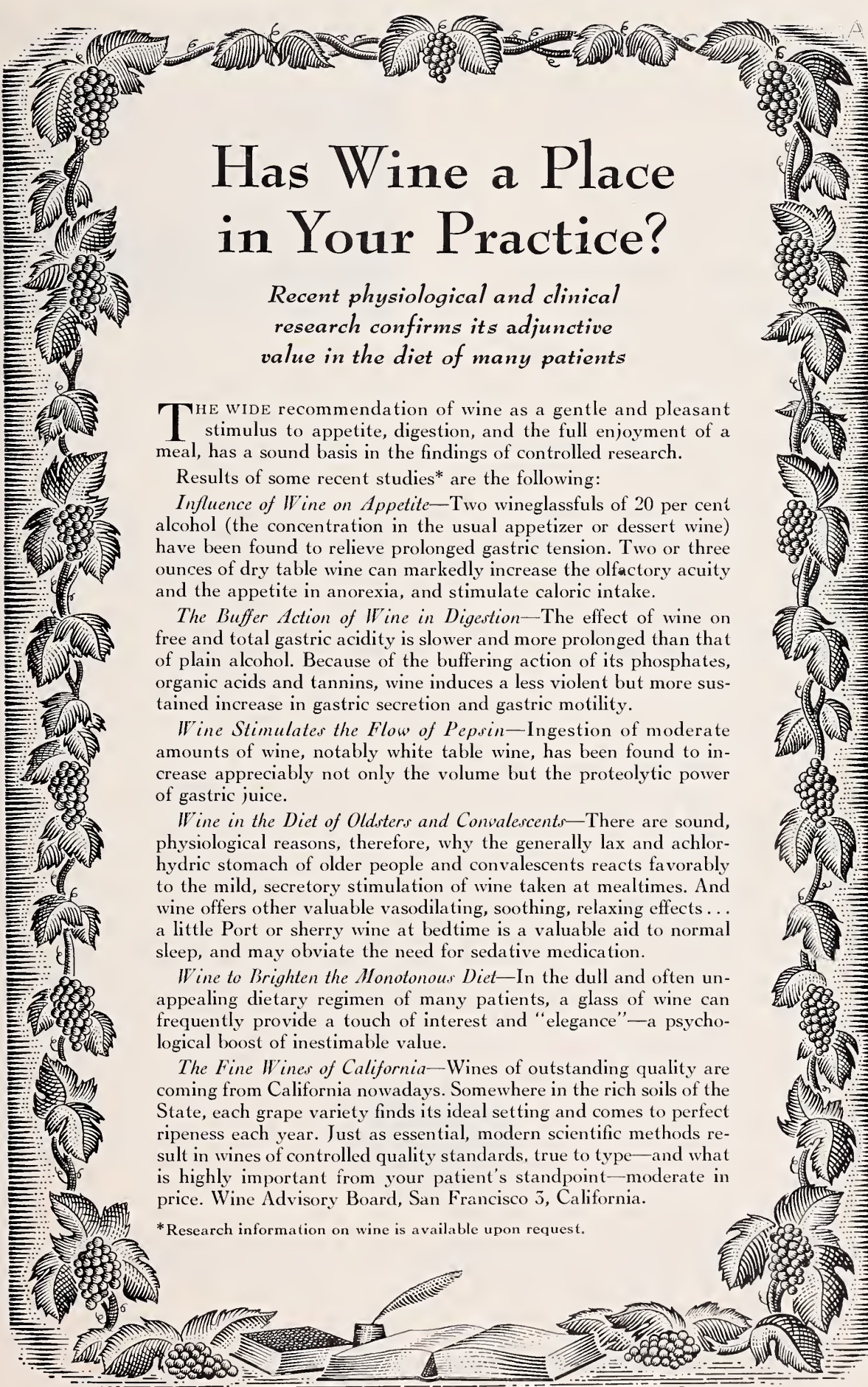
JAMES E. BAUGH, Milledgeville, has announced the opening of offices on West Hancock Street for the practice of medicine. Dr. Baugh is a graduate of the University of Georgia and the Medical College of Georgia. He interned at the Madigan Hospital in Tacoma, Wash. For the past three years he has participated in a residency training program at the Milledgeville State Hospital. During World War II he served with the 82nd Airborne Division. Dr. Baugh is immediate

past president of the Baldwin County Medical Society.

We regret to announce the death of Mrs. David P. Belcher, wife of DAVID P. BELCHER, Pelham, on August 21, 1954, following an extended illness. Funeral services were held at the Hand Memorial Methodist Church with interment in the Pelham City Cemetery.

JOE C. BROWN and ROBERT M. MARTIN, Conyers, have announced the recent removal of their offices to the new Rockdale County Hospital.

GUY C. CALK, Atlanta, was married August 28, 1954, to Miss Ann Elizabeth Jones of Atlanta. The wedding took place at the home of the bridegroom's uncle and aunt, Dr. and Mrs. OLIN S. COFER on Lullwater Road. Groomsmen were C. W. COOLIDGE, Atlanta, and C. H. HOUSTON, Jacksonville; HUGH GREGORY ushered. Dr. Calk recently began the practice of medicine in Atlanta; his bride, a gifted musician, is first harpist with the Atlanta Symphony Orchestra.



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The Buffer Action of Wine in Digestion—The effect of wine on free and total gastric acidity is slower and more prolonged than that of plain alcohol. Because of the buffering action of its phosphates, organic acids and tannins, wine induces a less violent but more sustained increase in gastric secretion and gastric motility.

Wine Stimulates the Flow of Pepsin—Ingestion of moderate amounts of wine, notably white table wine, has been found to increase appreciably not only the volume but the proteolytic power of gastric juice.

Wine in the Diet of Oldsters and Convalescents—There are sound, physiological reasons, therefore, why the generally lax and achlorhydric stomach of older people and convalescents reacts favorably to the mild, secretory stimulation of wine taken at mealtimes. And wine offers other valuable vasodilating, soothing, relaxing effects . . . a little Port or sherry wine at bedtime is a valuable aid to normal sleep, and may obviate the need for sedative medication.

Wine to Brighten the Monotonous Diet—In the dull and often unappealing dietary regimen of many patients, a glass of wine can frequently provide a touch of interest and "elegance"—a psychological boost of inestimable value.

The Fine Wines of California—Wines of outstanding quality are coming from California nowadays. Somewhere in the rich soils of the State, each grape variety finds its ideal setting and comes to perfect ripeness each year. Just as essential, modern scientific methods result in wines of controlled quality standards, true to type—and what is highly important from your patient's standpoint—moderate in price. Wine Advisory Board, San Francisco 3, California.

*Research information on wine is available upon request.

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L. C. CHEVES, JR., Montezuma, attended the recent Southern Pediatric Seminar held at Saluda, N. C. Approximately 185 physicians attended the post graduate course in diseases of children.

W. S. COOK, Albany, has been awarded a 25-year service emblem for his service as medical representative for the Atlantic Coast Line Railroad. Dr. Cook has been practicing medicine in Albany since 1909.

FLOYD E. DAVIS, Waycross, recently appeared on the Lone Ranger Program in the interest of health and safety for children. The Lone Ranger's Health and Safety Club has a list of 12 health and safety rules, and Dr. Davis' remarks at the end of the program stressed the need for children and adults to carefully follow these rules.

RICHARD A. DODELIN, formerly of Blackshear, has recently moved to Atlanta where he will serve a residency practice in orthopedic surgery at Grady Memorial and Emory University Hospitals.

G. H. FOLSOM, Lakeland, was honored recently on the occasion of his 77th birthday with a dinner at his home in Lakeland. Present were his seven children and their families.

WILLIAM T. GIST, Summerville, has recently returned to private practice after a two-year tour of duty with the armed forces. Dr. Gist served with distinction in Korea for which he was awarded the Bronze Star.

ROBERT B. GREENBLATT, Augusta, will be one of the principal speakers at the 1954 Scientific Assembly of the California Academy of General Practice to be held in Los Angeles October 24-27, 1954. The topic of his address will be "Uses and Abuses of Endocrine Therapy". Dr. Greenblatt was honored in the August issue of *Modern Medicine* magazine by being pictured on the publication's cover. He also has an article in the issue.

L. H. GRIFFIN, Claxton, is moving his clinic to new quarters on Liberty Street, Claxton. It will be a seven bed clinic with reception rooms for white and colored patients, business office, doctor's office, two examining rooms, laboratory, X-ray lab, operating room, kitchen and three baths.

On August 13, 1954, TOM HARBIN, Rome, addressed the annual meeting of the Georgia Vocational Rehabilitation Association on the subject, "Recent Developments in Cataract Surgery". Dr. Harbin is president of the Georgia Society of Ophthalmology and Otolaryngology.

WILLIAM HARBIN, Rome, spoke to the Rome Kiwanis Club in August on the many improvements made in medicine in recent years. He mentioned new drugs and antibiotics, new surgical techniques and new treatment methods. Dr. Harbin said the growth of pre-payment plans—health insurance—has been phenomenal in recent years, and this offers one of the best approaches toward lowering the cost of medical treatment, a goal toward which the entire medical profession is now working.

WILLIAM WYCLIFFE HILLIS, JR., Sardis, was married September 5, 1954, to Miss Agnes Cassels of Macon at the Vineville Methodist Church, Macon.

JAMES BENJAMIN KAY, JR., Augusta, announces the opening of his office for the practice of urology at 1419 Gwinnett Street, Augusta.

SALMON KOFF, Atlanta, announces the association of SIDNEY ISENBERG in the Koff Psychiatric Clinic, 119 Eleventh Street N. E.

A. HAMBLIN LETTON and JOHN PAGE WILSON, Atlanta, announce their association, succeeding the former partnership T. C. DAVISON and A. H. LETTON, in the practice of general surgery and gynecology, 207 Doctors Building, Atlanta. Dr. Davison died September 17, 1953.

We regret to announce the death of Mr. William Frederick Minnich, 74, father of W. R. MINNICH and F. R. MINNICH, both of Atlanta, on August 10, 1954, after an illness of two months.

IRVIN PHINIZY of Augusta has recently opened offices in Lincolnton for the practice of medicine. His offices are in the back of the Crawford-Breazeale Drug Store. Dr. Phinizy is a graduate of the Medical College of Georgia and has recently completed his internship in the University Hospital, Augusta.

WILLIAM C. RETTERBUSH, Valdosta, announces the opening of his offices at 1000 N. Patterson Street for the practice of surgery.

The American Legion Auxiliary of Cedartown held its regular monthly meeting on August 17th; DONALD SCHMIDT was the guest speaker. Dr. Schmidt had as his topic of address "Cancer and You".

HART SYLVESTER, Hawkinsville, has opened his offices for the practice of medicine and general surgery in the new wing of the Taylor Memorial Hospital, Hawkinsville. Dr. Sylvester received his M.D. degree from Tulane University, and his internship was served at Memorial Hospital in South Bend, Ind.

P. LEE WILLIAMS, JR., Cordele, has reported for active military duty with the U. S. Navy at Pensacola. He was commissioned a lieutenant, senior grade, and assigned to the surgery section of the Escambia General Hospital.

THOMAS H. WILLIAMS, Macon, announces the opening of his office at 873 Hemlock Street, Macon, with practice limited to general surgery.

BENJAMIN WILLS, Savannah, recently addressed the physical science class at Armstrong Evening College. Dr. Wills spoke on narcotics, stressing their resultant effects when taken in moderate or poisonous doses. CHARLES WESTERFIELD was also a guest lecturer. He selected as his topic hypnosis and modern-day anesthetic administration for people undergoing surgical treatment.

Physicians and research scientists from more than 40 countries attended the Second World Congress of Cardiology in Washington, D. C., September 12 through 17. The medical gathering was combined with the 27th Scientific Session of the American Heart Association, and is the largest and most important cardiovascular meeting ever held in the Western Hemisphere. A. CALHOUN WITHAM, Augusta, and H. B. JONES, Augusta, spoke to the section on Occupational Cardiology and Rehabilitation on the subject "Mass Survey Technique in Heart Disease".

Dr. Oppenheimer Retires

Russell H. Oppenheimer, who for the past 33 years has been associated with the Emory University School of Medicine, retired as professor of medicine and director of postgraduate education at Emory August 31.

Known to hundreds of students, past and present, as "Dr. Op", he has won a national reputation in the field of medical education.

Dr. Oppenheimer joined the staff of Grady Memorial hospital in Atlanta as the first resident physician in the Emory University division in 1921. Under him, the teaching program in the hospital took form, and today teaching is carried on throughout the municipal hospital.

A native of Fremont, Ohio, Dr. Oppenheimer received his bachelor's degree from Ohio State University. After a stint of teaching in a one-room schoolhouse where he taught everything "from singing to mathematics", he entered the medical school of the University of Michigan. He received the M.D. degree in 1917.

From the time of his graduation from medical school, except for a period of service with the Army in World War I and 20 months of private

practice in Detroit, Dr. Oppenheimer has been associated with Emory University.

He has held many of the positions he has filled at Emory concurrently. From 1924 until 1937 he was superintendent of the university hospital, and from 1925 through 1945 he served as dean of the School of Medicine. Dr. Oppenheimer has also served as professor of medicine, medical director of the university hospital and professor of clinical medicine. He developed Emory's postgraduate medical education program and has worked until the present in building and directing the program.

His service has not been confined to the university. Dr. Oppenheimer has been a leader in medical-civic affairs during his years here. When Battle Hill Haven, a home for the aged and chronically ill, opened in Atlanta he agreed voluntarily to supervise the medical care of patients without compensation. For the past seven years, he has given two full afternoons a week to this work. He has also served on the board of trustees of the Atlanta Tuberculosis association and on the medical committee of the Social Planning Council.

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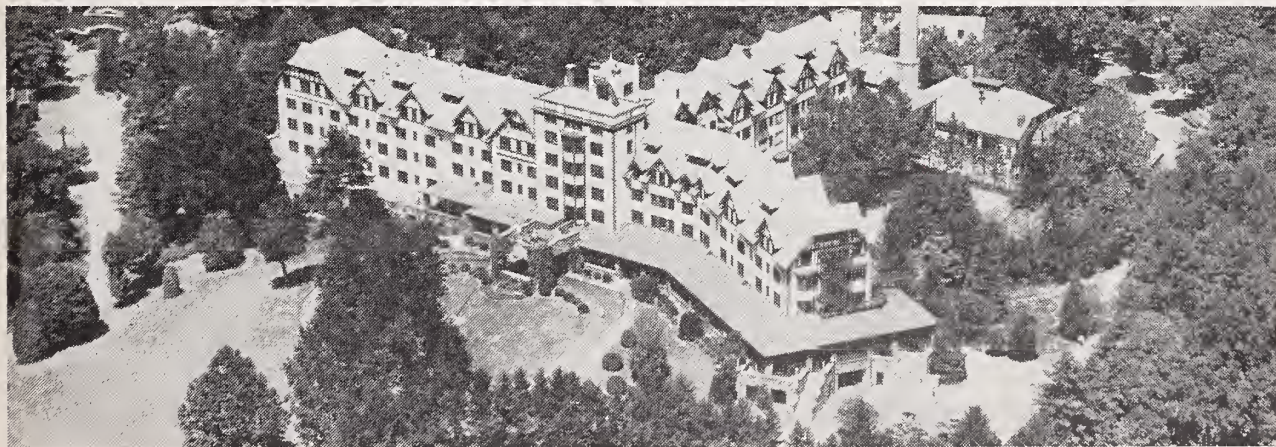
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1. Greenblatt, R. B., and Kupperman, H. S.: M. Clin. North America 30:576 (May) 1946. 2. McGavack, T. H., in Goldzieher, M. A., and Goldzieher, J. W.: Endocrine Treatment in General Practice, New York, Springer Publishing Company, Inc., 1953, p. 225.

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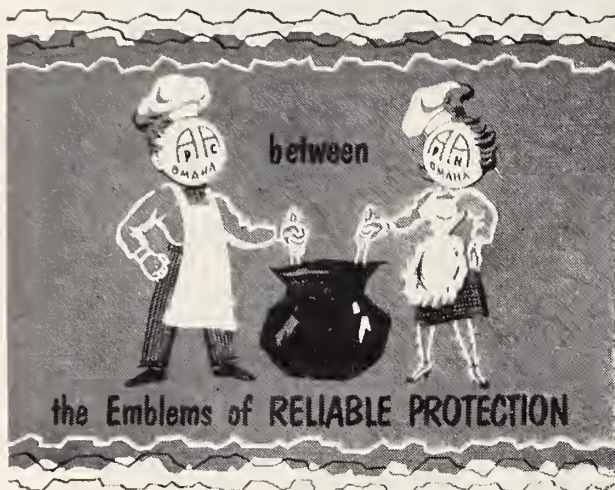
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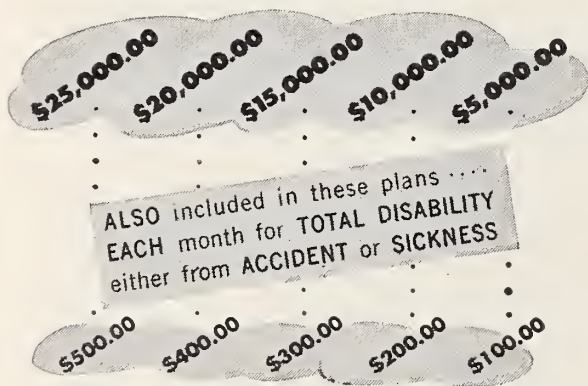
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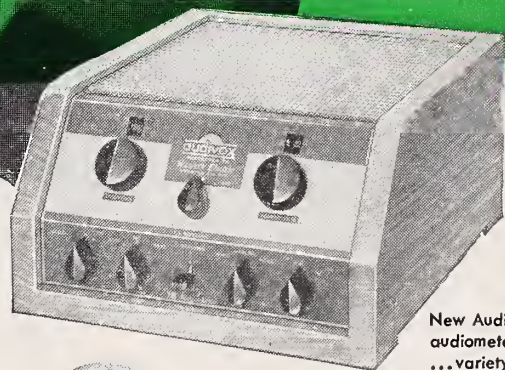
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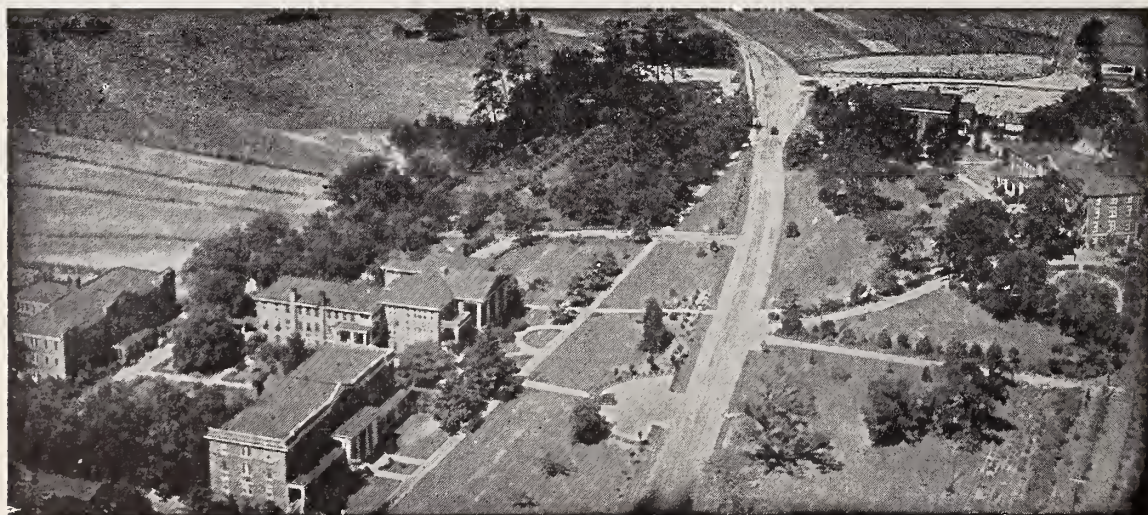
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875 West Peachtree, N. E.
Atlanta, Georgia

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Articles are accepted for publication on the condition that they are contributed solely to this *Journal*. Manuscripts should be typewritten, double-spaced and the original and two copies should be submitted. Receipt of manuscripts will be acknowledged and unused manuscripts returned. Used manuscripts will be returned only if requested.

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COVER—The cover picture this month, taken by Ted F. Leigh, M.D., symbolizes the real significance of Thanksgiving. The church is the Roswell Presbyterian Church, but it could be your church—anywhere in Georgia on Thanksgiving, 1954.

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Only Viceroy has this new-type filter. Made of a non-mineral cellulose acetate—it gives the greatest filtering action possible without impairing flavor or impeding the flow of smoke.

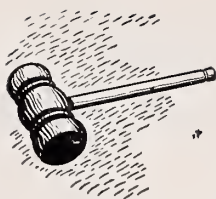
Smoke is also filtered through Viceroy's king-size length of rich, costly tobaccos. Thus, Viceroy smokers get *double the filtering action* . . . for only a penny or two more than brands without filters.

WORLD'S LARGEST-SELLING FILTER TIP CIGARETTE

New King-Size
Filter Tip **VICEROY**

ONLY A PENNY OR TWO MORE
THAN CIGARETTES WITHOUT FILTERS





president's page

November is the month of the year when our nation collectively gives thanks for our many blessings.

We are thankful that there is no war and pray that peace will continue its progress. We are thankful that scientific medicine is on the march, and we should therefore expend our energies toward the advancement of medical care for our fellow man. Where there are differences of opinion there should be understanding and reconciliation. The proverbial chain is only as strong as its weakest link, so the chain of continuity and integrity of the medical profession is only as vigorous as its individual units. Uncorrected personal and factional differences will be the downfall of our profession. Certain groups, both lay and professional, would rather see the fall of medicine's reputation than its advancement.

Let us remember our predecessors, their contributions to medicine and their good moral influences in the profession and in the communities in which they lived and practiced.

Let us realize that medicine is greater than any of us, but that if each of us will do his part we will have a profession for which we can all be genuinely thankful.

A handwritten signature in cursive script, likely belonging to the president of the organization at the time.



HABERSHAM COUNTY HOSPITAL

Demorest, Georgia

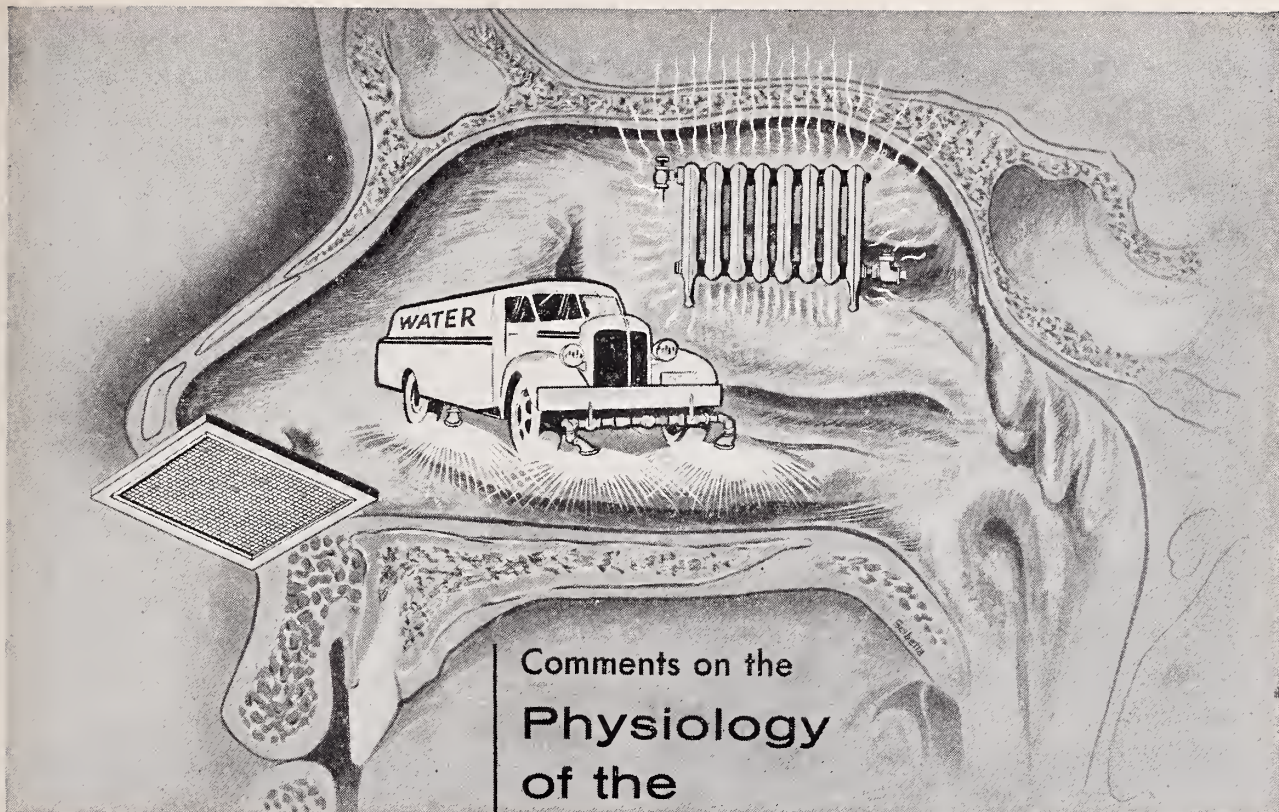
The Habersham County Hospital at Demorest, Georgia, was opened for the reception of patients in the summer of 1952. This hospital has a capacity of 43 beds. It is the first public hospital in that county.



STEPHENS COUNTY HOSPITAL

Toccoa, Georgia

An addition to the Stephens County Hospital was completed and put in operation in July 1952. This enlargement provided 16 additional beds, better operating room facilities, food service department and other improvements. The total bed capacity is now 49.



Comments on the Physiology of the Upper Respiratory Tract

THE NASAL CAVITY:

The main functions of the nasal cavity are conditioning and exchanging air between the atmosphere and the lungs, as well as smelling. Gross impurities are removed by the fine nostril hairs, and finer impurities are enveloped in the mucous secretion of the intranasal lining and carried away by ciliary action. The air is warmed to a degree approaching body temperature and humidified. About 500 cc. of air are taken in during an ordinary inspiration, totaling 12,000,000 cc. daily.

In the common cold . . . when hypersecretion and mucosal swelling interfere with the normal aeration pattern, when abnormal mouth breathing is resorted to as a distress measure, relief can be obtained promptly with topical application of Neo-Synephrine hydrochloride. This potent vasoconstrictor is usually well tolerated — produces practically no sting or irritation on application to mucous membranes — even in infants.

NEO-SYNEPHRINE® hydrochloride



Winthrop-Stearns INC.
NEW YORK 18, N. Y. WINDSOR, ONT.

0.25% Solution
0.5% Solution
0.25% Solution (Aromatic)
1% Solution
0.5% Jelly
0.25% Emulsion

Nasal Spray
*Plastic, unbreakable,
leakproof squeeze bottle;
delivers fine even mist.*

Neo-Synephrine (brand of phenylephrine), trademark reg. U. S. Pat. Off.

HIGHLAND HOSPITAL, INC.

Founded in 1904

ASHEVILLE

NORTH CAROLINA



Affiliated with Duke University

A non-profit psychiatric institution, offering modern diagnostic and treatment procedures—insulin, electroshock, psychotherapy, occupational and recreational therapy—for nervous and mental disorders.

The Hospital is located in a 75-acre park, amid the scenic beauties of the Smoky Mountain Range of Western North Carolina, affording exceptional opportunity for physical and nervous rehabilitation.

The OUT-PATIENT CLINIC offers diagnostic services and therapeutic treatment for selected cases desiring non-resident care.

R. CHARMAN CARROLL, M.D., *Diplomate in Psychiatry. Medical Director.*

ROBT. L. CRAIG, M.D., *Diplomate in Neurology and Psychiatry. Associate Medical Director.*



HILL CREST SANITARIUM

FOR NERVOUS AND MENTAL DISEASES AND ADDICTIONS

Insulin and Electro-Shock Therapy Used in Selected Cases. Gradual Reduction Method Used in the Treatment of the Addictions

Thoroughly modern in architecture and construction. Eight departments—affording proper classification of patients. All outside rooms attractively furnished. Several bathrooms and rooms with private bath on each floor. Also a spacious sun parlor in each department. Located on the crest of Higdon Hill, 1,050 feet above sea level, overlooking the city, and surrounded by an expanse of beautiful woodland. Ample provision made for diversion and helpful occupation. Adequate night and day nursing service maintained. Catalogue sent on request.

James A. Becton, M.D., Physician-in-Charge
P. O. Box 2896, Woodlawn Station, Birmingham, Alabama

James Keene Ward, M.D., Associate Physician
Phones 9-1151 and 9-1152

The Full-Liquid Diet pulls its own weight!

Packing good nutrition into the full-liquid diet for your patient who must stay on it a long time is sometimes difficult. But with a blender or egg beater, almost any food can be used.

Mix the same foods many ways—

Strained chicken in milk makes "bisque"—in tomato juice it's "creole." Strained liver and bacon double-times the same way.

Your patient may like cottage cheese whipped into milk flavored with chocolate and mint, or he can blend it with cranberry juice sparked with lime.

Strained carrots go in milk, broth, or pineapple juice. Flavor the milk blend with nutmeg, the broth with parsley, and the juice with cinnamon and brown sugar. An egg or skim milk powder may be added for a protein bonus.

Strained fruits in fruit juices do well with a squeeze of lemon or a touch of mint.

Then serve them up with dash—

Bright colored drinks look good in clear glass—pale ones in gayly painted glasses. And if a mixture looks drab, hide it in a bean pot or a round jam jar wrapped in a napkin.

Add a bright plastic straw. And for garnish, try a sprinkle of spice, a spoonful of sherbet, a dab of whipped cream, or a lemon slice hooked on the edge of the glass. Or frost the rim by dipping the glass in water, then in sugar.

Of course, only you can tell your patient *just which foods* he can and must have for his specific condition. But these suggestions can help guide him within the limits you set.



United States Brewers Foundation

Beer—America's Beverage of Moderation

pH 4.3; 104 calories/8 oz. glass (AVERAGE OF AMERICAN BEERS)

If you'd like reprints for your patients, please write United States Brewers Foundation, 535 Fifth Avenue, New York 17, N. Y.

KARO SYRUP

BELONGS IN THIS PICTURE!

... a carbohydrate of choice
in milk modification for 3 generations

OPTIMUM caloric balance—60% of caloric intake, gradually achieved in easily assimilable carbohydrates—is assured with Karo. Milk alone provides 28%, or less than half the required carbohydrate intake.

A MISCIBLE liquid, Karo is quickly dissolved, easy to use, readily available and inexpensive.

A BALANCED mixture of dextrans, maltose and dextrose, Karo is well tolerated, easily digested, gradually absorbed at spaced intervals and completely utilized.

PRECLUDES fermentation and irritation. Produces no reactions, hypoallergenic. Bacteria-free Karo is safe for feeding prematures, newborns, and infants—well and sick.

LIGHT and dark Karo are interchangeable in formulas; both yield 60 calories per tablespoon.



CORN PRODUCTS REFINING COMPANY
17 Battery Place, New York 4, N. Y.



association mail

To Dr. Ted F. Leigh:

Note that you were the guest Editor for the Emory Centennial number of the *Journal of the Medical Association of Georgia* for September. Looked through this issue with a great deal of interest, particularly your introduction. The issue was most attractive from the front cover to the end of the *Journal*. It was splendidly done.

Sincerely,

C. P. Loran
Secretary-Manager,
Southern Medical Association

To the Editor:

I wish to express appreciation to you and to other members of the publications committee of the *Journal of the Medical Association of Georgia* for the very generous presentation of the Centennial of Emory University School of Medicine which was published in the September issue of your *Journal*.

Cordially yours,

R. F. Whitaker
Assoc. Director Development
Emory University

To the Editor:

In the September issue of your *Journal*, in the article on Emory's Centennial, the statement was erroneously made that Doctor William Caton is the first full-time professor of Obstetrics and Gynecology in Emory Medical School.

As all Emory doctors know, Doctor James R. McCord was the first full-time head of the department and professor of Obstetrics and Gynecology for some 29 years, prior to his resignation in 1946. He served faithfully and well, and really brought national recognition to this school in clinical teaching of Obstetrics and Gynecology.

I feel sure that you would like to make this correction.

Yours very truly,

Charles B. Upshaw, M.D.
Atlanta, Ga.

To the Secretary-Treasurer:

The whole world loves its doctors. I would be completely amiss if I did not start immediately with a feeble effort to pay a tribute to Dr. Louie

Bauer our Secretary-General for U.S.A. When our social and economic revolution has taken a lull, some hundred or so years from now, Dr. Bauer will be known as the great spirit of medicine: he having preserved the ideal that the affections in which a physician is held is a greater asset than our economic or social security. The highlight of the meeting was when he presented, in four languages in sequence, the flag to Rome. This was at the banquet given by the federated licensed physicians of our host city.

The prevailing attitude toward social security was that we should study plans that are best suited to each country. A discussor that identified himself as Dr. H. H. V. Lodhia of the Burma Medical Association, a most impressive figure of a man, made this point most effectively. He used the illustration that Coca-Cola, whether it is good or bad, has built a world wide empire on publicity alone. He also states that in India social security seems to mean cheaper and cheaper medicine; to this Nehru exclaimed in exasperation that the cheapest thing a person could do was to die.

It was also my impression that the greatest fault of medicine under social security is that when medicine is free it is taken in an alarmingly increasing amounts, even to the extent of absorbing unemployment or welfare benefits. However, no other country uses the tons and tons of aspirin and laxatives that the U.S.A. and Canada do.

You would have especially enjoyed the session on editorial responsibility in medical publications. Papers should be confined to medical experience and medical experimentation on the sick. Experimentations on the normal volunteer should best be left out of medical journals, as the significance cannot be too easily applied to the treatment of the ill. Foreign papers sent in should be reviewed quite carefully; too often when the person is not well known he is what one might call a bit of a go-getter and will sell you a bill of goods. Advertisements should be properly placed and entirely free from any suggestion that there is a scientific value and free from the appearance of a scientific article.

A thought from the scientific version is this: in antibiotic therapy a relapse suggests an original error of diagnosis, inadequate treatment or, what is most important, the possibility of a new disease.

Illustration of each point: in typhoid fever, chloramphenicol rids the intestinal ulcers, not the lymphatics, of the typhoid bacillus; but other organisms can maintain the ulcers. A patient, feeling well, eating heartily and walking about, can perforate or hemorrhage. Carrying this thought further, vaccines can be advantageously used as a supplementary treatment with chloramphenicol. While antibiotics do not prevent immune reactions there is still the possibility of an early negative base. They are not Ehrlich's "Magic Bullets".

The trip to Naples, a guide ambles through the ruins of Pompeii which was completely beyond my wildest imaginations like nothing else, beside the Italian lira; lunch at Ciro's; a reception by the Mayor of Naples in the Castle of Albano II. He greeted everyone with handshakes and repeated the handshaking when each left.

Other impressions were the influence of Lucullus on European life, Frankfurt am Main, under den Pluma Surteu, Muenchen "machts nichts und am prosit"; the Greeks had a word for it, the Italians a remedy; the reception at the Instituto Farmateraputa Italiano; back to matches, soaps, segregation of the sexes and relatives. What Rome lacked in soap it more than made up for in size of towels. I will have to see you personally to tell you about Pompeii and "for men only B.C. circa 800."

Till seeing you,
H. Dawson Allen
Milledgeville, Georgia

To the Secretary-Treasurer:

I wish to thank you and the Medical Association of Georgia for the telegram wishing the Georgia Dental Association a successful 87th annual meeting.

Your telegram was read at the annual dinner of our convention and was well received.

Again thanking you, I am

Sincerely,
Dr. Harvey Payne, President
Georgia Dental Association
Atlanta, Ga.

To the Editor:

In looking over some of the back issues of the "Journal" for another purpose, I noticed again the Editorial on "Mechanical Psychiatry" in the November 1953 issue. I wondered if you received many comments on this controversial subject and have learned that you have not.

At the present stage of our knowledge of psy-

chiatry and the effects of any treatment administered to the psychiatric patient, it seems that electro-shock treatment has its place. It is indicated as the adjuvant treatment of choice for carefully selected patients; it is contra-indicated for all others.

That electro-shock treatment involves the psychiatrists emotionally, those who "are not button pushers" as well as those who "do administer such therapy" is a fact of significance. This is one of the reasons for the timeliness of the Editorial last November—and probably for some Novembers to come.

The physician who wrote "Mechanical Psychiatry" is apparently not a psychiatrist. This alone is impressive to me and I believe is worth emphasizing; what he writes indicates a concern for his patients that should not be lacking in any physician; it opposes the practice of a physician's rejecting those who present themselves with a dysfunction in the emotional sphere; it implies too that the appropriateness and manner of referral of any patient is a part of the physician's responsibility in treating the patient. The referral for treatment; what specific physician would be best suited for this patient; what are the techniques of referring any patient? I believe there is a very special need for study of the techniques of asking the patient to be seen by a psychiatrist—too often the patient is allowed to interpret this as another slap in the face.

There is much expensive delay in the patient's progress that is caused by inadequate understanding between psychiatry and the rest of medicine. No better illustration of this comes to mind than the fact that this editorial was written, was necessary to write, was written none too soon, but could not be expected to alter to an appreciable degree the existing gulf between general medicine and this specialty.

In my opinion the main reason that the Editorial Page must be used as the medium for contacting psychiatry is that we do not have an official organization of the psychiatrists in Georgia. A Georgia Psychiatric Society would enable communication across that gulf to be not only possible but easy, and the value would be enhanced because the communication would be in either direction. Properly established this foolish barrier to the effective treatment of patients would be avoided.

Sincerely,
John M. Anderson, M.D.
Atlanta, Ga.

the executive secretary's letter

Editorial Comment

As reported earlier, the Headquarters Office visitation to each and every county medical society president and secretary nears completion. Results of this program are both heartening and discouraging. Societies with a membership of 15 or more members are usually active and seem to carry the bulk of the workload of organized medicine. Societies with less than 15 members are, in general, fairly weak in organization, seldom meeting, and in some cases existing only on paper. Some 45 out of 80 component societies are in this category with too few notable exceptions.

The MAG and its 80 component county medical societies represent the physicians of Georgia. Basic

to any state association is the effectiveness of each of its county units—the county medical society. If these units are not functioning, the “weak links” break the whole organization. Merely paying dues is no indication of participation—the Association cannot function efficiently with less than half of its supporting units.

The Headquarters Office is dedicated to revitalizing these units but this can be accomplished only if the physicians in the county society care enough to do their part of the job. Minimum standards for county society organization are being established, and it remains the members' responsibility to meet these essentials and weld a stronger Association of the profession in Georgia.

AMA-General Practitioner, 1954

James B. Kay, Macon, voted MAG General Practitioner of the Year at the 1954 MAG Annual Session, Macon, was nominated by MAG Council for the AMA General Practitioner of the Year. This honor is given annually by the AMA to a GP selected from the nominees of each state association. C. H. Richardson, Macon, will be chairman of the committee which will present data on Dr. Kay to AMA at the AMA November meeting.

MAG Council

Your attention is called to the minutes of the meeting of the Association's Council held September 19, 1954, which appears on page 968 of this issue of the *Journal*. These minutes give a brief account of the important matters discussed by your representatives who gather to discuss *your* business. Their activity in your behalf certainly deserves your interest.

Forward Look

The Association *Journal* staff, Contributing Editors and Publications Committee met October 20

to reevaluate the purpose and function of the state medical journal. Edgar Woody, Jr., Editor, presented plans for the 1955 MAG *Journal* which were approved. A new cover design for the magazine was proposed, and each section of the *Journal* was reevaluated in the light of the importance of its contribution to better coverage of *all* activity in Georgia medicine.

Audit and Appropriations

The MAG Audit and Appropriations Committee meets later this month to prepare the 1955 MAG Annual Budget. Chairman Chambers has requested that all MAG Committee Chairmen and interested parties submit their requests for monetary appropriations to him; his committee is concerned now with the task of their 1955 budget recommendations. This becomes the first order of business at the scheduled December Council meeting.

MAG Roster

Preparation of the annual MAG roster of members to be published in January will be completed December 31, 1954. Formerly published as part

of the *Journal*, this roster will be mailed you as a separate booklet for your use in 1955. Another innovation is printing an alphabetical list of MAG membership in addition to the membership listing by county society. The alphabetical list will serve when the physician's area of practice is not known. The roster will also carry a complete list of specialty society memberships for your further convenience.

Physicians Placement

Because of some justifiable controversy over the validity of "Locations Seeking Physicians" run monthly in the *Journal*, the MAG Rural Health Committee will carefully screen any location before it is printed in the *Journal*. This will then eliminate the listing of locations not having a genuine need for a physician. Constructive criticism from county societies concerning this service paved the way for this needed supervision.

1955 Dues

Suffice it to quote from the MAG Constitution and By-Laws on an annual subject as follows: "dues—shall be levied per capita upon the members of the Association. They shall be *payable on or before January 1st* of the year for which they are levied. The secretary of each component society shall cause to be collected and shall forward to the office of the Association the dues for its members, together with such data as shall be required for a record of its officers and membership. Any member whose name has not been reported for enrollment and whose dues for the current year have not been remitted to the Secretary-Treasurer of the Association on or before April 1st, shall stand suspended until his name is properly reported and his dues for the current year properly remitted. At no time and under no circumstances shall a member make payment of dues directly to the Secretary-Treasurer of the Association. Neither shall the Secretary-Treasurer of the Association receive payments of dues from anyone except the secretary of the component county medical society or his representative."

Please cooperate with your county society secretary so that his job in collecting 1955 dues may be a little less difficult than in prior years.

All MAG Committeemen

The majority of the MAG committees have increased their activity and are planning to meet before the Christmas season. Committees notably active are Audit and Appropriations, Scientific Work, Professional Conduct, Maternal Welfare,

Medical Defense, Constitution and By-Laws, Public Relations, Rural Health, Insurance Board, American Medical Education Foundation, Blood Banks and the Anesthetic Study Commission. This list speaks well for the Association, and committee chairmen and members are to be commended.

Officers Newsletter

Recently instituted, for the information of all MAG and County Society Officers and MAG Committee Chairmen, is a newsletter sent out from the Headquarters Office at least twice monthly. This letter carries four or five items of real importance to the Association. Some 250 physicians receive this letter, and it provides an immediate relay of essential information. This office will be glad to send the newsletter to any member physician who requests it: if you wish to receive it, please notify the Headquarters Office so that your name can be placed on the mailing list.

Public Health Liaison

As the year advances, it is interesting to note how many MAG Committees have been or are being reactivated. And with their projects the MAG grows strong and fulfills its tremendous responsibilities.

Certainly recognition must also be given the Georgia Department of Public Health. A vast program in Public Health has been initiated and administered by the Department, and their cooperation with the MAG has greatly aided MAG Committee Chairmen. Public Health Department personnel have aided in planning MAG agendas, have offered technical and secretarial assistance and have always been most cooperative.

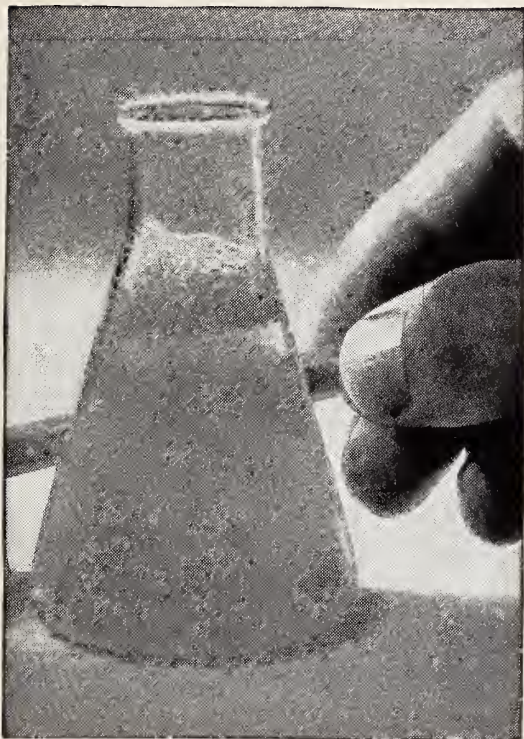
The MAG Public Health, Rural Health, Hospital, and Maternal and Infant Welfare Committees have sought background material from this state agency; they have relied on charts and statistical material supplied by the Department and have received invaluable advice in their activities. More and more, the MAG and this Department of the state are solving mutual problems through liaison, and the MAG has leaned heavily on the personnel and facilities of the State Department of Public Health.

The medical profession in Georgia can well be proud of its relationship with the Department and should seek even greater liaison to effect solutions to the many problems facing the profession.

Milton D. Krueger
Executive Secretary

ORAL BICILLIN

REQUIRES NO ACID BUFFERS!



"... the use of added acid buffers is not required for oral administration; ... because of the limited solubility of benzathine penicillin G [BICILLIN] in the stomach, it is not highly susceptible to destruction by gastric juices."¹

After $\frac{1}{2}$ hour in artificial gastric juice (pH 1.6), BICILLIN remains relatively insoluble, and is nearly 75% active. (BICILLIN used at a concentration of 2000 units per ml., approximating the antibiotic concentration in the stomach after a dose of 300,000 units.)

- Unlike other forms of penicillin, Oral BICILLIN requires no acid buffers to resist gastric destruction. This is because Oral BICILLIN is relatively insoluble. Acid tests² show that this insolubility persists for hours in artificial gastric juice (pH 1.6), that Oral BICILLIN retains full penicillin potency of its undissolved portion—71.7% after $\frac{1}{2}$ hour, 31.1% after 3 hours, 18.1% after 6 hours.

Resistance to acid destruction is a surety factor in penicillin absorption—a safeguard for therapeutic effect.



Supplied: Oral Suspension BICILLIN: Bottles of 2 fl. oz.—300,000 units per 5-cc. teaspoonful; 150,000 units per 5-cc. teaspoonful. Tablets BICILLIN: Vials of 36—200,000 units per tablet; bottles of 100—100,000 units per tablet.

1. American Medical Association: *New and Nonofficial Remedies*, 1954. J. B. Lippincott Co., Philadelphia, p. 147
2. Scott, R. L., and others: *Antibiot. & Chemo.* 4:691 (June) 1954



Philadelphia 2, Pa.

B I C I L L I N[®]

Benzathine Penicillin G (Dibenzylethylenediamine Dipenicillin G)

PENICILLIN WITH A SURETY FACTOR

Meat...

and Its Contribution to Fat Needs

Fat, the most concentrated source of nutrient energy, constitutes a dietary essential in human nutrition.¹ It is needed in growth and replacement of tissues, for specific lipid secretions, and for providing physiologic energy.^{1,2} Absorbed fatty acids may be incorporated into more complex lipids, deposited in adipose tissue, converted into other fatty acids, used in production of milk fat, transformed into glucose or glycogen, or oxidized to carbon dioxide and water with liberation of energy.³

Evidence indicates that long continued extremely low fat intake in adults is incompatible with good health.^{4,a} In addition to protecting tissue protein against catabolism for energy needs (the protein-sparing action of fat), sufficient amounts of fat in the dietary promote storage of protein.^{4,b} In a normal mixed diet, fat is about 95 per cent as efficient as carbohydrate for production of muscular work.^{4,c}

Neither the optimal level of fat in the diet nor the optimal range for apportionment of fat and carbohydrate to meet calorie allowances is known.^{1,2}

Contrary to general impressions, fat in the mixed diet is effectively digested.^{4,d} In moderate amounts it does not appreciably influence the digestibility of other foods.⁵ Fat enhances the satiety value of meals, and foods naturally containing fat and those prepared with fat add much to the flavor value of meals. High fat diets sometimes are useful in alleviating constipation.⁶

Meat, according to its kind and cut, provides variable amounts of fat which contribute importantly to the body's need for fat. The fat of meat is almost completely digested. Meat also supplies valuable amounts of high biologic quality protein, B vitamins, and essential minerals. Skeletal muscle meat contains less than 0.1 per cent of cholesterol.⁷

1. Goldsmith, G. A.: Application to Human Nutrition, in Bourne, G. H., and Kidder, G. W.: Biochemistry and Physiology of Nutrition, New York, Academic Press Inc., 1953, chap. 23, p. 505.
2. Recommended Dietary Allowances, Washington, D. C., National Academy of Sciences—National Research Council, Publication 302, 1953, p. 23.
3. Ekstein, H. C.: Fat in Nutrition, in Handbook of Nutrition, A Symposium, ed. 2, Philadelphia, The Blakiston Company, 1951, p. 23.

4. Sherman, H. C.: Chemistry of Food and Nutrition, ed. 8, New York, The Macmillan Company, 1952, (a) p. 30; (b) p. 198; (c) p. 115; (d) p. 103.
5. McLester, J. S., and Darby, W. J.: Nutrition and Diet in Health and Disease, ed. 6, Philadelphia, W. B. Saunders Company, 1952, pp. 130-135.
6. Smith, F. H.: The Use of High Fat Diets for Constipation, J.A.M.A. 88:628 (Feb. 26) 1927.
7. Okey, R.: Cholesterol Content of Foods, J. Am. Dietet. A. 21:341 (June) 1945.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.




American Meat Institute
Main Office, Chicago... Members Throughout the United States



a good "mixer"
for your cough prescriptions

especially valuable when allergic factor
is suspected or present



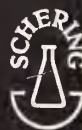
Chlor-Trimeton syrup q.s. ad

- taste appeals to young and old
- compatible with commonly prescribed medications

Contains CHLOR-TRIMETON® Maleate
(brand of chlorphenpyridamine maleate), 2 mg. per teaspoonful (4 cc.).

Schering

CHLOR-TRIMETON SYRUP



now patients will enjoy your low-sodium diet

Taste CO-SALT and know why this different salt substitute so truly satisfies the cravings of your low-sodium diet patients for the flavor of salt.

CO-SALT so closely looks like, sprinkles like and tastes like salt . . . there is . . .

in congestive heart failure
toxemias of pregnancy
hypertension
obesity



1. no "cheating" on the prescribed diet
2. patients enjoy their food again
3. patients are better nourished

Lithium-free, never bitter or metallic in taste, contains nothing that may deplete the system of phosphorus or other minerals. The only salt substitute that contains choline. For use at table or in cooking.



INGREDIENTS: choline, potassium chloride, ammonium chloride and tri-calcium phosphate

available: 2 oz. shaker top package
8 oz. economy package

professional samples upon request

Accepted for advertising in the Journal of the American Medical Association.

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250 East 43rd Street - New York 17, N. Y.

Cancer of the Mouth

ELLIOTT SCARBOROUGH, M.D., Atlanta, Ga.

THE OUTLOOK for cure and/or palliation has been greatly improved for the patient suffering from mouth cancer. The public has become aware of the need for early treatment. Dentists and physicians who have reason to examine the mouth regularly are more alert to the presence of both precancerous and cancerous changes. The patient and the physician have learned that cancer is the most important ulceration or tumefaction occurring in the mouth. They know that biopsy is mandatory and should be repeated if the report does not support the clinical suspicion. A positive test for syphilis in the presence of ulceration may mislead unless biopsies have been done to determine the possibility of cancer.

Cancer of the mouth is a disease of the older age group, usually with a greater incidence in men than in women. The reason is found in the generally recognized fact that chronic irritation over a long period of time—15 to 25 years—plays a definite part in the development of many mouth cancers. It is significant that cancer occurs commonly on the lower lip amongst outdoor workers such as farmers, sailors, etc. whose lips are exposed to sun, wind and cigarettes and bathed in oral secretions. Syphilis, chronic non-specific glossitis, vitamin and iron deficiency and tobacco seem to contribute to the development of cancer in the mouth and usually give a history of being present for many years—15 to 25.

Mouth cancer is predominantly a lesion of the lining epithelium. This accounts for the fact that 90 per cent of it is epidermoid carcinoma. Adenocarcinoma occurs usually in the hard palate or base of the tongue from minor salivary gland origin. Rarely melanomas, lymphomas and sarcomas are encountered. It is necessary to know the type of growth in order to understand the life history and anticipate the course of the disease. Other important factors for this understanding are

the location and extent of the disease. This is determined by a good examination with adequate light and exposure combined with gentle palpation.

The histological grade is indicative of the growth potential but may be misleading if considered alone. Tumors showing low histological grade do not always offer a good prognosis nor those showing high grade a poor one. Radiosensitive and radioresistant grading must be understood to be another estimation of the biology of the tumor by the pathologist for the benefit of the clinician and does not necessarily mean that the radiosensitive ones should be treated with irradiation nor the radioresistant ones with surgery.

It is generally recognized that starting with the lip the epidermoid carcinoma is usually well differentiated and that as one goes backward in the oral cavity, whether on the tongue, buccal mucosa or palate, the differentiation of the cells becomes less and the grade higher; metastases occur earlier; and they may be wider spread.

The extent of the process refers to the size of the tumor and local or distal involvement. In some instances, usually associated with leukoplakia, the points of origin are multiple and may be separated as far as from one side of the buccal mucosa to the opposite side. Fortunately this is sometimes superficial cancer but may vary from widespread intra-epithelial to multiple high-grade discrete infiltrating foci. In both instances the surgical extirpative procedures may be out of the question.

Mouth cancer metastasizes usually in an orderly and predictable fashion to the lymph nodes in the neck. Cancer in the anterior third of the mouth usually involves the superficial lymph node in the submaxillary triangle on the same side. The lower lip and floor of the mouth sometimes involve the submental node and rarely the node above the head of the clavicle without any intervening lymph node involvement. The upper lip

sometimes involves the node in the cheek or maybe behind the posterior belly of the digastric muscle. The middle third of the mouth including the tongue most commonly involves the deep node at the bifurcation of the carotid artery. This is the most important deep cervical lymph node in the neck. The posterior third of the mouth, including the base of the tongue and soft palate, frequently involves the high nodes behind and adjacent to the parotid salivary gland as well as the node at the carotid bifurcation. They also extend bilaterally when in the midline.

The tongue is the most commonly involved area in the mouth and probably has the most serious consequences. Fortunately cancer usually occurs on the lateral border of the tongue and most often in the middle third. It almost never occurs on the dorsum of the tongue, except at the base, unless associated with diffuse syphilitic glossitis. In advanced stages the entire tongue may become involved with resultant pain, fixation and salivation.

Cancer in the buccal mucosa may extend directly through the cheek or invade the masseter muscle and cause varying degrees of trismus. It may involve the mandible and result in its loss or osteomyelitis.

Cancer in the floor of the mouth quickly extends directly into the submucosa and usually involves the submaxillary and sublingual salivary glands.

In the hard palate the antrum is frequently invaded.

The treatment of early cancer of the mouth may be successfully accomplished either by surgical or radiological measures. Many times one is used when the other has failed. Decision as to choice of treatment is frequently not easy because, in addition to the consideration of the above related biological aspect of the local disease, the biology of the patient as a whole and even the social and economic considerations have to be taken into account. With the improvement in surgical care before, during and after the operation, few tumors in the mouth can be considered inoperable provided one is willing to sacrifice face and function sufficiently. It then becomes the responsibility of the surgeon to be sure that the contemplated procedure offers enough chance of cure or even relief of suffering to justify recommending it. It is in this field where the greatest recent advances have occurred.

*Winship Memorial Clinic
Emory University Hospital*

Memorial to Lewie H. Muse, M. D.

The loss of Dr. Lewie H. Muse is not only felt very keenly by his colleagues in the medical profession, but certainly will be realized by his host of friends and patients. He was a man who by his inspiration spurred younger men to emulate his success; who by his zeal urged others in his chosen specialty to greater heights and who, with his great knowledge, taught many students, interns and residents the art and science of the practice of pediatrics. The influence of Dr. Muse will live long in the memory of all who knew and loved him.

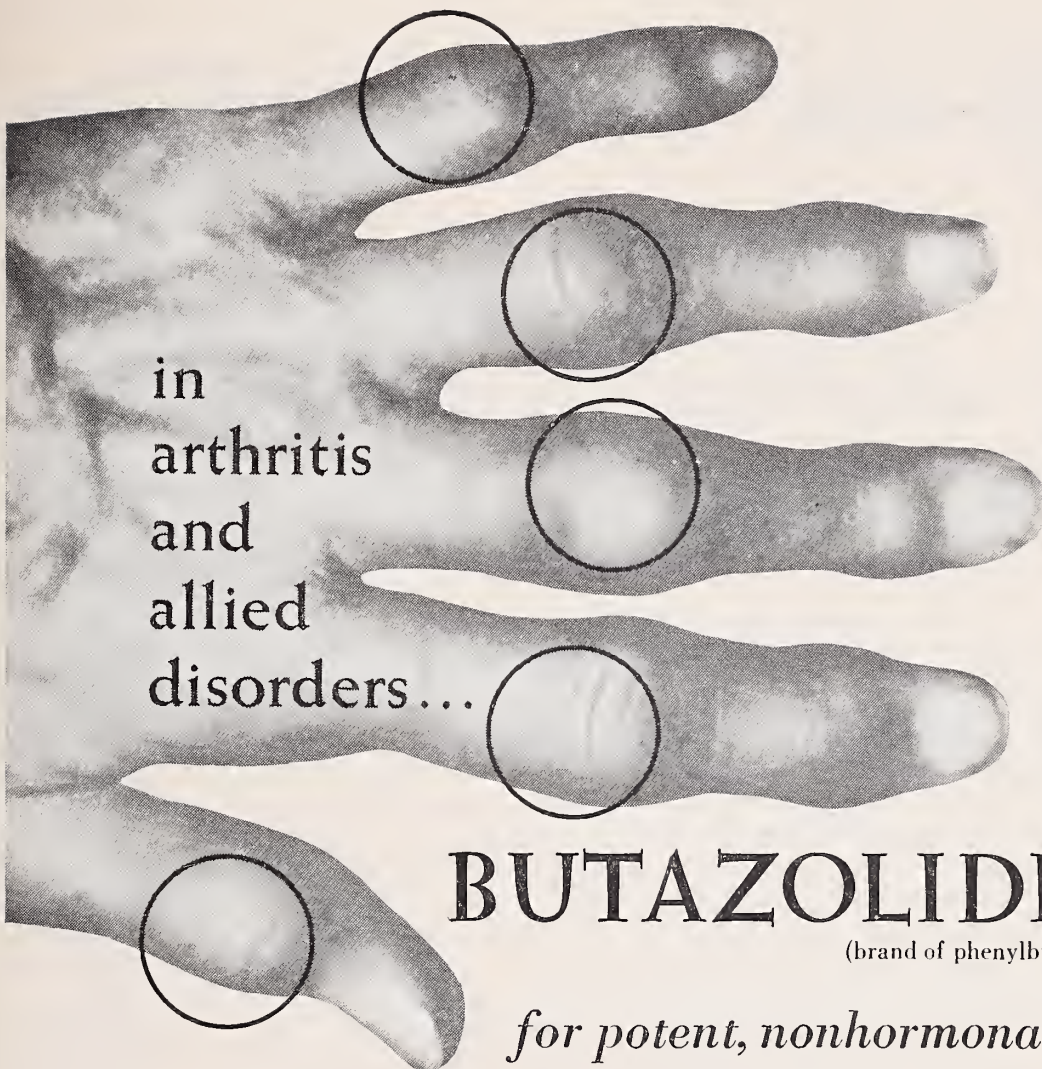
It is the strong feeling of the Atlanta pediatric group that a suitable memorial be established for one of our most beloved members. To this end a committee has been appointed to formulate plans by which this may be accomplished. The committee feels that every doctor in the Atlanta area, as well as statewide, who knew and loved Lewie H. Muse would appreciate being able to contribute to

a fund which would perpetuate his memory in a most fitting manner.

It is planned to have an oil painting of Dr. Muse reproduced from photographs, and to have a bronze plaque cut as an epitaph. The committee hopes also to develop a lectureship or some other fitting memorial. The privilege of contributing to the Lewie H. Muse Memorial Fund should be one participated in by all of us, and it is hoped the fund will be sufficient to perpetuate the living and loving memory of one who was very dear to all of us.

All contributions should be made out to The Lewie H. Muse Memorial Fund and sent to Dr. C. Dixon Fowler, 27 8th St., N.E., Atlanta, Ga.

Committee: Don F. Cathcart, M.D.
T. F. Davenport, M.D.
C. Dixon Fowler, M.D.
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*MacKnight, J. C.; Irby, R., and Toone, E. C., Jr.: *Geriatrics* 9:111 (Mar.) 1954.

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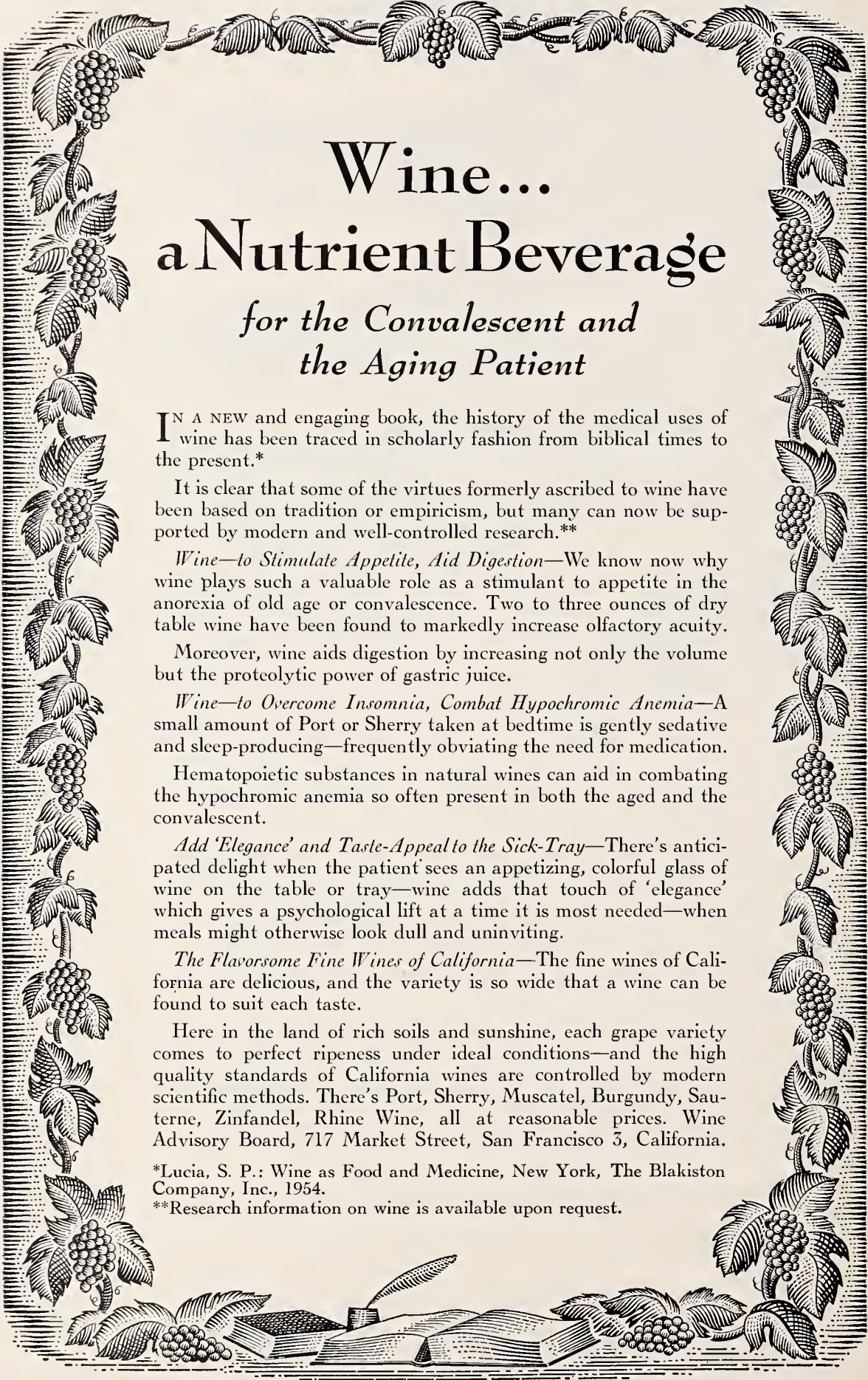
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*Lucia, S. P.: *Wine as Food and Medicine*, New York, The Blakiston Company, Inc., 1954.

**Research information on wine is available upon request.



C-Reactive Protein in Acute Rheumatic Fever

THE ETIOLOGY OF rheumatic fever is not specifically established, and it may be that a specific diagnostic test and a specific treatment must await this information. In recent months, however, a known immunological procedure has been re-studied, which, though non-specific, has a certain use in the diagnosis of the acute phase of rheumatic fever.

The relationship between human inflammatory disease and the C-reactive protein is old information; what is new is the observation that this protein is *constantly* present in the sera of patients with clinical rheumatic fever, a constancy that has not been demonstrated in other inflammatory illnesses and other collagen diseases.

The known immune response that is the basis of this test is the flocculation of acute inflammatory disease serum by the somatic C-polysaccharide of the pneumococcus. The specific fraction of the serum which reacts is the C-reactive protein. A few facts are known about its properties: it is an alpha globulin; it can be separated with the lipid fraction of the plasma; it can be purified and crystallized; it is serologically distinct from other serum proteins. From this pure human protein an antiserum can be made by rabbit passage, and this anti-serum will give a clear semi-quantitative precipitate when mixed with sera from patients having acute rheumatic fever diagnosable clinically.

The clinical usefulness of this procedure is apparent in the statement that the positive test parallels clinical activity and nothing more. What is wanted, and badly, is some measurement of sub-clinical activity during the convalescent stage; although the C-reactive protein has not been thoroughly studied in this zone between activity and inactivity, the indications are that it will not be helpful. Furthermore, there is no certainty with a positive test that the clinical illness is rheumatic fever, since a variety of other inflammatory diseases produce this response.

It is noteworthy, however, that a negative test means the absence of active rheumatic fever. This would seem valuable information. Discounting rheumatic fever on clinical grounds is not always easy, and a test to eliminate this possibility is welcome. It is conceivable that this test can spare a normal child several months of bed rest, and if so, it is valuable indeed.

It should be realized that the immunological basis for this reaction is quite different from the antistreptolysin titer. In the latter instance what is measured is the rising bacteriological evidence of an antecedent streptococcal infection, only circumstantial evidence of rheumatic fever. In the former instance evidence of the rheumatic state is measured, by using a protein elicited during inflammation, a closer step to the specific nature of rheumatic fever.

Notes on practical aspects of cardiovascular diseases . . .
a monthly contribution of the Georgia Heart Association.



REVIEWS

ATLAS OF OPERATIVE TECHNIC, ANUS, RECTUM, and COLON, By Harry E. Bacon, M.D., B.S., Sc.D., F.A.C.S. F.R.S.M., F.I.C.S., F.A.P.S.; and Stuart T. Ross, M.D., A.B., F.A.C.S., F.I.C.S., F.A.P.S.; The C. V. Mosby Company, 1954, Price \$13.50.

This atlas provides an excellent guide for the surgeon who performs abdominal colonic surgery and anorectal procedures. It gives a concise, step-by-step description and pictorial presentation of the various operative procedures. The volume is particularly valuable to an individual who wishes to briefly review the subject, rather than read it in a textbook. The operative procedures in this atlas are the ones most frequently used in regard to diseases of the anus, rectum and colon and include improved methods and technique which have been developed during the recent years.

General considerations are given to the surgical anatomy of the anorectum and colon, preoperative and postoperative care of these patients, anesthesia, basic instruments used in the operative procedures and the methods of opening and closing the abdomen.

The atlas is divided into two parts. The first part deals with anorectal operations for malformations of the anus and rectum, cryptitis, anal fissure, rectal abscesses, fistula-in-ano, pruritus ani, hemorrhoids, polyps, prolapse of the rectum, anal stenosis, incontinence and pilonidal sinus.

The second part deals with colonic operations and includes the procedures for decompression of the colon in different types of obstruction, the removal of polyps, resection of the colon, abdominoperineal resection with or without preservation of the sphincters and exenteration of the pelvis.

This publication is valuable reference for any physician interested in this subject and will be an asset to his library.

William C. McGarity, M.D.

EMERGENCY TREATMENT AND MANAGEMENT, by Thomas Flint, Jr., M.D. Director, Division of Industrial Relations Permanente Medical Group Oakland and Richmond, California; Chief, Emergency Department Permanent Medical Group, Kaiser Foundation Hospital, Richmond, California. W. B. Saunders Company, Philadelphia-London, 303 pages, 1954.

This book, a guide to emergency room room procedure and treatment, is divided into three sections consisting of a total of 128 subject headings. The first section, entitled General Medical

Principles and Procedures, consists of 10 broad subject headings including general principles governing barbiturate and narcotic prescriptions as needed in the emergency room; rules governing the obtaining of blood for alcohol content tests; serum administration and desensitization; and use of x-rays and fluroscopy in the emergency room.

The second section consists of subject headings 11-114 and covers emergency treatment of specific conditions which the author feels fairly well cover the range of possibilities. The third section covers headings 115-128 and is concerned with administration, clerical and medicolegal procedures and is in the reader's opinion the most valuable section of the book. Of particular importance is the emphasis placed upon adequate records in the emergency room and the necessity for obtaining legally valid emergency treatment permits. Also touched upon are a number of other subjects, including photography of emergency room patients, the dispensing of information concerning emergency room patients and the handling of service personnel and dependents.

The care of the emergency room patient demands a thorough grounding in both medicine and surgery as well as the exercise of the utmost in diagnostic acumen. If the person who undertakes emergency treatment does not have these qualities, reference to this book will not be of much help, and to a properly trained physician the book would be unnecessary.

W. Lawrence Salter, M.D.

PLANNING FLORIDA'S HEALTH LEADERSHIP, A Summary by Russell S. Poor, Ph.D., Univ. of Florida Press, Gainesville, 1954, 93 pages, \$1.50.

Physicians of Georgia and the Southeast will be interested in the development of a health center at the University of Florida. In this small volume the author has summarized concisely the findings of an exhaustive study of Florida's health needs and outlined the manner in which the University of Florida can best undertake to provide the personnel and service required. The Lippard-McLean¹ report made February 1, 1949, included eight essential points to be considered by the State of Florida and its university in planning a medical school and associated services. On the basis of this report the university received a mandate from



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the legislature to establish a school of medicine and a school of nursing, to be located on the university campus at Gainesville. In 1950 the university architects began to study plans for the necessary buildings, and in 1951 the legislature appropriated \$100,000 for the development of these plans.

J. Hollis Miller, president of the university, recognized that study and planning for this undertaking constituted a research problem of large magnitude, and he outlined wisely the principles to be followed. He stated that the university should have a medical center which would provide the medical personnel and services needed by the state with its rapidly growing population; that it should be a first-class medical and nursing school; that "the new school should be so designed physically and program-wise as to meet the needs of the people of Florida;" and, further, that the center should be an integral part of the university and "not established at the expense of the needs for our existing professional schools and colleges." Having stated the case, President Miller sought and obtained a grant of \$96,500 from the Commonwealth Fund to finance the study. The next important step was the appointment on July 1, 1952, of Dr. Russell S. Poor, a distinguished scientist and educator, as director of the health center study. The director and his staff worked with six committees of the university faculty and met frequently with an executive committee composed of men of long experience in medical education, research and service. About 200 scientists and educators were either visited at their own institutions or brought to the university for consultation and advice.

The following major items were considered by Dr. Poor and his associates:

(1) Florida's need for physicians, nurses, ancillary personnel and for medical services. This need was based upon present supply and anticipated requirements for the future. To maintain the present ration of physicians to population, 140 new doctors would be needed each year while the estimated ideal need would be 173 annually.

(2) The need for clinical services in the health center to the community and state.

(3) Medical education in a university setting should seek to avoid a too-narrow scientific approach, and pre-professional education should be broad and liberal and not vocational.

(4) The units of the health center were to include schools of medicine, nursing and pharmacy, with a school of dentistry to be added if the need

existed and support could be found. A general hospital of 500 beds with outpatient facilities would provide clinical instruction for classes of 50 medical students each.

(5) Organization, administration, personnel and finances. Prevailing attitudes rather than the mechanism of administration would determine whether or not the health center would meet its educational objectives. Proper balance must be kept between research, service and education. It was thought that administration should not cost more than eight to nine per cent of the operating budget. Dr. Poor was appointed provost of the Health Center on August 1, 1953, and Dr. George T. Harrell was named dean of the College of Medicine on January 1, 1954.

The statement made by the Commonwealth Fund is significant: "The University of Florida is thinking like a university . . . it has taken steps to fit the center, not merely to the university matrix in which it will operate but to the state whose health needs it must serve." Because the University of Florida made an exhaustive study of all facets of the enterprise, the development of a first-class medical school and health center at Gainesville can be anticipated.

R. Hugh Wood, M.D.

Footnote (1) Dr. Vernon W. Lippard, dean, Yale Univ. School of Med. directed this study. Dr. Basil C. McLean, director, Strong Memorial Hospital, Univ. of Rochester, later collaborated. The entire report was critically reviewed by an advisory committee consisting of: Dr. Donald G. Anderson, secty., Council on Med. Ed. & Hosp., A.M.A., Dr. Arthur C. Bachmeyer, assoc. dean, Div. of Biol. Sc., Univ. of Chicago, Dr. Joseph C. Hinsey, dean, Cornell Univ. Med. Col. and pres. elect, Assoc. Am. Med. Colleges and Dr. W. T. Sanger, pres., Med. Col. of Va.

TEXTBOOK OF PEDIATRICS by Waldo E. Nelson. W. B. Saunders Company, Philadelphia and London, 1954, 1581 pages, 478 figures, \$15.00.

Dr. Waldo Nelson, chief of pediatrics at Temple University School of Medicine, has produced a sixth edition of the now familiar *Textbook of Pediatrics*, first edited by Griffith, then Griffith and Mitchell, and lately Mitchell and Nelson. This is the first edition on which Dr. Nelson's name has appeared alone.

No less than 72 contributors are represented in this edition, all very important people in their various fields. Dr. Milton J. E. Senn has compressed into his section what amounts to a complete book on pediatric psychiatry, presenting not only seldom-seen psychoses but all of those pediatric bugaboos such as thumb-sucking, "nervousness," nail-biting, teeth grinding, unreasoning fears and the rest of the habits children acquire

which are of such paramount concern to parents of developing progeny. He attempts to point out what the pediatrician's responsibilities are in these matters and at what point they should be referred to a psychiatrist; at all times he stresses the importance of regarding these presenting complaints as symptoms of some underlying defect in the feelings and attitudes of the family and the necessity of evaluating properly and dealing with the family as a whole.

Dr. Katherine Dodd has ably condensed the basic essentials of parenteral fluid therapy into a readable and practical few pages which cover the subject as well as is possible in a limited space.

The old section on blood disorders has been reorganized by Dr. Louis Diamond to bring it up to date with the recent (and current) intense interest and developments in this area of medicine, particularly in the field of defects in hemostasis.

There is an entirely new short section on burns by Dr. Robert H. High, assistant professor of pediatrics at Temple, which is adequate and takes a conservative stand on burn treatment.

The other new section is one on radiation injury by Dr. Robert W. Miller of the University of Rochester and the Atomic Bomb Casualty Commission in Hiroshima. He points out that the child of today is apt to have repeated exposure to ionizing radiations, and there is a possibility that his tolerance may be dissipated since his longer life provides him with a greater opportunity than the adult to exhibit late effects.

The entire book, which of course covers the entire field of pediatrics, has been modernized in regard to developments since the last edition in 1950, notably in regard to cortisone, ACTH and the newer antibiotics.

The book as a whole, despite the addition of several new sections, is about 100 pages shorter than the previous edition, representing revisions and editing in almost all the chapters. This has been done with dexterity by Dr. Nelson, and the result is a textbook which will be standard equipment for medical students, house staff officers and practitioners.

Olin Shivers, M.D.

DIAGNOSIS AND TREATMENT OF THE ACUTE PHASE OF POLIOMYELITIS AND ITS COMPLICATIONS by Albert G. Bower, M.D., Los Angeles, California; Williams and Wilkins, Baltimore, Md., 1954, 250 pp, \$6.50.

This book is composed of contributions from 14 authors, which concern the diagnosis and the care of the patient with acute poliomyelitis. The

material presented has been edited by Dr. Bower, and the end result is an excellent reference book for the medical practitioner. For the most part, the contributors are members of a team at the Los Angeles County Hospital, and the book represents their wide experience in diagnosis and treatment of poliomyelitis.

The treatment of respiratory failure and aberrations of the breathing mechanism have been given great emphasis because with the rarest of exceptions, no patient dies of acute poliomyelitis except as a result of respiratory failure. The maintenance of a clear air way, and the indications for and management of the tracheotomy patient are well presented. Respirators and other mechanical aids to respiratory difficulty in acute poliomyelitis are well discussed and illustrated.

Every phase of diagnosis and treatment of poliomyelitis in the acute form is covered, including diagnosis, medical management, pulmonary complications, nursing procedures, orthopedic treatment, biochemical changes in polio and physiotherapy.

In the opinion of the reader, this book is designed primarily as a ready reference for the practitioner in communicable disease wards or centers where poliomyelitis care is a specialty, but would also be most informative to the general practitioner, pediatrician and orthopedist who sees occasional poliomyelitis patients, especially from the standpoint of handling respiratory difficulties.

William J. Peebles, M.D.

FUNDAMENTALS OF OTOLARYNGOLOGY. A textbook of Ear, Nose and Throat Diseases. By Lawrence R. Boies, M.D., Clinical Professor of Otolaryngology, University of Minnesota Medical School, Minneapolis. Associates: Charles E. Conner, M.D., et. al. Second edition. Cloth \$7, Pp. 487, with 197 illustrations. W. B. Saunders Company, Philadelphia and London, 1954.

With the progressive changes in Otolaryngology a second edition by Doctor Boies has brought into focus many of the opinions that have been accepted as factual since his initial book on this subject. This material has been very capably presented and enlightens the undergraduate student and the physician who is not a specialist, as to the fundamentals of nose, throat and ear diseases. It is an elementary book and serves a very useful purpose in undergraduate teaching capacity. Certain revisions have been made since the first edition was published four and one-half years ago and some additions made to offer a current teaching guide with new concepts. It serves as a good book for study by those for whom it is intended.

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1. Allen, E.V.; Barker, N.W.; Hines, E.A., Jr.; Kvale, W.F.; Shick, R.M.; Gifford, R.W., Jr., and Estes, J.E., Jr.; Proc., Staff Meet. Mayo Clin. 29:459 (Aug. 25) 1954.
2. Livesay, W.R.; Moyer, J.H., and Miller, S.I.; J.A.M.A. 155:1027 (July 17) 1954.

3. Wilkins, R.W.; Mississippi Doctor 30:359 (Apr.) 1953.

4. Kert, M.J.; Rosenfeld, S.; Mailman, R.H.; Westergart, J.P.; Carleton, H.G., and Hiscock, E.; Angiology 5:318 (Aug.) 1954.



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Tissue Committees

TISSUE COMMITTEES are something relatively new. Many have heard of them and are possibly somewhat suspicious of their functions, while others have worked with them and have become fully aware of their value. They have been encouraged by the American College of Surgeons and adopted by the Joint Commission of Accreditation of Hospitals as a requirement of hospital staff organizations.

Simply defined, a tissue committee is a committee of members of the medical staff of a hospital which evaluates surgery done by the staff. It is one answer to the problem of unnecessary surgery, and it is the best known method of providing adequate control of surgery done in the hospitals. It is a prime example of self-discipline by the staff of a hospital.

The composition of the committee is important. The members should be conservative, thoughtful physicians from various segments of the profession, general practitioners as well as representatives from the different specialties. They should be men who understand the need of discipline in the profession, and who are prepared to stand up for what they think. A pathologist is essential: unless all tissue is properly diagnosed, the clinicians of the tissue committee will be unable to evaluate the surgery properly. A proper philosophy is important. Each member should have an understanding of the many diversified problems

in the practice of medicine, a cognizance of the fact that there are differences of opinions on the cure of diseases and a realization that mistakes will be made.

To be effective the committee must be accepted by the hospital staff. This is the greatest immediate obstacle. A frequently used policy for the initial year is simply to report to the staff whether or not faulty medicine is being practiced and to bring examples when found to the staff's attention. Even though there is no identification of doctor or patient, the individual physician can identify his case to himself. This may result in many instances in self-discipline, which is gratifying. Even later the committee should not have any disciplinary powers: fact finding and making recommendations are its only prerogatives. It should make periodic general reports to the staff, but any specific case action must come through the executive committee.

As statistics are accumulated from hospitals throughout the country it has been shown that where tissue committees have been functioning for a year or more there has been definite decrease in unnecessary surgery. On the positive side, improvement in work-ups and preoperative diagnoses are observed. These general principles may well be applied to any of the services in a hospital which should lead to the better practice of medicine.

Surgery of Diaphragmatic Hernias

THE ALERT physician sensitive to the possibility of hiatus hernia as the cause of his patient's obscure gastrointestinal bleeding, anterior chest pain, dyspnea and palpitation is making the diagnosis more often. He is confusing this entity less frequently with cholecystitis, cholelithiasis, peptic ulcer, cardiac disease, cancer of the cardia, stricture of the esophagus and intestinal obstruction. And, as Carter¹ has pointed out, the

incidence of traumatic hernias is increasing with the present emphasis on speed in transportation, the variety and number of crushing injuries and steering wheel incidents. It is possible now to cure the large majority of those individuals who have troublesome hiatus hernias where conservative measures are no longer indicated. And in addition, with the aggressive surgical treatment of traumatic diaphragmatic hernias, lives are being saved.

Progress in the technics of thoracic surgery has gone hand in glove with this sharpened acumen of the doctor who first thinks of the possibility and then makes the diagnosis of a diaphragmatic hernia. Harrington's classification of hernias through the diaphragm includes two main categories, non-traumatic and traumatic. In the former group are those hernias associated with some congenital defect. These involve deficiencies in the diaphragmatic partition in the posterior aspect (foramen of Bochdalek), the esophageal opening (hiatus hernias) and the anterior portion (foreamen of Morgagni). The traumatic group includes those caused by direct trauma, indirect trauma and inflammatory necrosis. In the case of direct injury to the diaphragm, the hernia may occur at any point and usually is the result of a knife or bullet wound. If the injury has been indirect, the rupture may occur at any focus including those of embryologic fusion. The most common place is in the left diaphragm, either in the dome or in the left posterior aspect. The hernia, characteristically the result of a severe crushing blow, may occur in the right diaphragm. If it involves the esophageal hiatus it is associated with a sac, but if through the leaf of the diaphragm there is no sac. With inflammatory necrosis the explanation may be a subdiaphragmatic abscess or drainage tubes in empyema cavities, which erode the surface of the diaphragm.

The most common hernia of the diaphragm seen in the newborn is that through the foramen of Bochdalek. This is a posterior rent in the partition and represents a failure of embryonic fusion. In the true sense, this abnormality is really not a hernia, for there is no sac involved. Instead, part of the abdominal viscera, often including the colon, spleen, small bowel, portion of the stomach and even the left lobe of the liver, may be in direct contact with the collapsed lung and deviated mediastinum. The diagnosis is characteristically made in the cyanotic and dyspneic infant after appropriate X-ray films have been taken revealing bowel loops in the chest and a shift of the mediastinum. It is unnecessary and may be dangerous to give barium in these cases. With the use of positive pressure anesthesia, using either a close fitting face mask or an endotracheal tube, surgical repair can be done from a thoracic or an abdominal approach with life saving results.

The most common nontraumatic hernia is that through the esophageal hiatus. There are three kinds of hiatus hernias: those in which varying

portions of the entire cardiac aspect of the stomach herniate through (sliding hernias); those where the lesser curvature portion of the esophagogastric junction is anchored at the esophageal hiatus and varying portions of the stomach, beginning with the greater curvature, herniate through (so-called upside down stomachs when marked); and finally the rare type where the esophagus is congenitally short with varying amounts of the stomach present in the chest from birth. Where indicated, repair of the first two of these is easily accomplished via a thoracic approach. Most authorities are now of the opinion that the superior exposure obtained using this technic enables a more satisfactory dissection and repair. In correcting the congenitally short esophagus, the most successful procedure possible has been to move the esophageal hiatus to a higher level. Left phrenic nerve divisions have been used with varying degrees of success. Some authorities consider this latter procedure a defeatist maneuver. The most infrequently seen hernia in the nontraumatic group is that through the foramen of Morgagni (anterior subcostosternal space of Larrey). There is a sac associated with this type, and it can contain omentum, part of the transverse colon and/or loops of small bowel. Clinically there may be symptoms of intermittent to complete intestinal obstruction, and on the PA chest films it is most commonly confused with pericardial cysts and dermoid tumors. This is the only type of diaphragmatic hernia where there is unanimity of opinion in the approach for repair. It is best accomplished through a subcostal incision, with the alternative of entering the chest across the costal arch where necessary.

Traumatic diaphragmatic hernias occur for the most part in adults. As have been pointed out by Harrington² and Churchill³ these so-called hernias are really not hernias, because again there is no sac present in the great majority of cases. There is actually an evisceration of varying abdominal viscera through rents in the leaves of either diaphragm, more often the left. During the recent war crises, wounds of the upper abdomen with concomitant involvement of bowel, diaphragm and lung were not uncommon. These patients were explored as soon as possible, and often through thoracoabdominal incisions. This allowed early repair of ruptured diaphragms with reexpansion of collapsed lungs, concurrent correction of mediastinal shifts and replacement of the abdominal viscera. In short order the normal cardiorespiratory physiology had been reinstituted

and the dangers of bowel strangulation and obstruction obviated. This was standard order of procedure in the military medical service, and although such direct wounds of the diaphragm and contiguous viscera are rarer in civilian life, the accepted treatment remains the same. Where the diagnosis of rupture of the diaphragm is made as a result of indirect trauma, and this is predominantly by appropriate x-ray films, the patient should be operated on as soon as possible with suture of the rent, replacement of the eviscerated abdominal organs and restitution of the cardiorespiratory physiology.

Traumatic rupture of the diaphragm is a surgical emergency. Even though there is no immediate evidence of a perforated viscus or a bleeding spleen or liver there is the very good possibility of setting the stage for incarceration, strangula-

tion and obstruction of the displaced bowel. It has been pointed out by Carter¹ et. al., that if a portion of the stomach is included in this evisceration into the chest, the abdomen may well be scaphoid and peristalsis audible, with a strangulated loop of transverse colon in the chest. It is good to study the patient, but if he be one with a known or suspected ruptured diaphragm one may, as Dr. A. O. Whipple has said, end up "studying him to death."

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Ethics and the County Medical Society

ORGANIZED MEDICINE has been criticized in recent magazine and newspaper publications for alleged unethical practices; in these articles the state or national medical organizations have been pointed out as failing to assume the role of prosecutor. Within the framework of American medical organization, the component county medical society is in the majority of instances the sole prosecuting agent and also holds both the power of adjudicating and the power of assessing penalties for infraction of the rules of ethical practice.

Therefore it would seem to be proper to point out to the officers and members of county organizations their responsibility in all cases where actual or alleged violations of medical ethics are at issue.

"The Principles of Medical Ethics" is an instrument of The American Medical Association, which is in turn a federation of state medical organizations who are bound under the Constitution and By-Laws to accept these principles as the rule and guide of ethical medical practices. The establishment and power of amendment and revision of the "principles" are functions of the

A.M.A. House of Delegates consisting of representatives of the various state organizations. "The Principles" is therefore the code of ethics by which all state and county medical organizations are bound. They are not laws or edicts *per se*, however, they definitely point out and designate ethical practices and procedures between physicians and patients, the public, other health organizations, media of disseminating factual information, etc.

The responsibility for membership in medical organization and enforcement of the correct ethical principles of medical practice rests almost solely with the local county society. Prospective members should be completely investigated concerning their training, experience and ethical background; adherence to this will insure the organization against admitting those who may at some future date be guilty of ethical infractions. The local county society is also responsible for adequately explaining to and informing the members of the importance of proper ethical procedures. Should a breach of ethics occur, then the county society, in accordance with their Constitution and By-Laws, and those of the state organization under which they have received their charter should

proceed with their duty of trial and adjudication in proper medico-legal form.

Many county medical societies have a committee, called one of various names, such as mediation, board of censors, medical ethics etc., whose explicit duty is to hear the complaint and arrange for its complete presentation to, and action by, the members of the organization. It is very imperative that every portion of the action, i.e. the initiation of the complaint, hearing and final disposal, follow the specific form or method contained in the local Constitution and By-Laws. Frequently these local actions are appealed first to the state medical organization, and then to the

Judicial Council of the A.M.A. In either instance a complete review of the action at the local county level is of primary importance, especially at the national level where the appeal is heard on the basis of law and procedure.

The local component county medical societies therefore have a function of great importance in the matter of adherence to ethically sound medical practice. Each county medical society is the sole judge of its members; they have the penal power to enforce the "Principles of Medical Ethics"; they should without hesitation vigorously oppose and prosecute violations of the time honored code.

Professional Conduct

IN THIS SEASON of Thanksgiving, we in the medical profession have much for which to be thankful. In a world where state control of medicine has expanded so rapidly in the past 10 years, we have by our own efforts in this country maintained intact the private practice of medicine. It was with pride and satisfaction that we witnessed the formation of defensive forces in Washington which turned back the imminent threat of socialized medicine. All of us, acting through our individual county medical societies, made such an effort possible. Most of us feel that without this powerful voice in Washington some form of state medicine would now exist. Let us not be lulled into a false sense of security by this temporary respite.

We all recognize the forces which oppose us and realize that they await another opportunity to test our unity. We must face the fact that these individuals who criticize our administration and distribution of medical care will always be with us, and that any lasting victory for private medicine must be won, not in Congress, but at the sources of all such complaints—the grass roots, the local communities. At the same time we are aware of those among us who do not bring credit to the profession, and that this small minority, through their deeds or words, is nullifying or going far to nullify the superior performance of the

majority. If we fail to take active measures toward disciplining ourselves from within, we must inevitably expect to be disciplined by those who know little or nothing of the true problems which confront us in the practice of medicine.

Through such media as tissue committees in the various hospitals and active grievance committees in our county medical societies, we can go far toward disciplining ourselves. We in the profession know best where our dirty linen lies, and it is up to us to take care of it—not to await its public airing to the detriment of all. One or two bad apples all too often may spoil the reputation of the barrel. If we do not exercise the fortitude to isolate and correct the few bad actors among us, then we may expect no letup in the pressure of public opinion against us. It is much less trouble to contribute to a Washington defense fund than to take a stand at the local level. It is encouraging to note that 10 of our county medical societies have within the past year recognized professional conduct problems and instituted positive action to correct the situations as they existed.

Defense in Washington is very important, but self-discipline at the local level is mandatory if we are to turn the tide of public opinion in our favor. It is a fact that our planning socialist brethren will have no fragment of truth on which to base their claims if we keep all of our house spotless.

Medical Personnel Problems in the Department of Defense

FRANK B. BERRY, M.D., Washington, D. C.



Frank Brown Berry, M. D.
Assistant Secretary
of Defense

IN JANUARY 1953 the Director of Defense Mobilization stated, "Acute shortages are continuing among highly skilled professional, scientific and technical workers needed in defense and essential civilian activities. . . . Under full mobilization the lack of such workers would be critical." The Office of the Assistant Secretary of Defense (Health and Medical) is intimately concerned with personnel needs of doctors, dentists and nurses in the armed forces. This problem will be with us for the next five years at least, and it is of equal interest to the civilian as well as the military medical, dental and nursing groups. The problem of shortages has been building up throughout the years. It was foreseen by the President in 1951 when he was President of Columbia University, and, under a grant from the Ford Foundation, the National Manpower Council, which made studies of scientific and professional manpower in 1952 and the utilization of scientific and professional manpower in 1953, was established. A number of interesting and pertinent facts have become evident as a result of these studies.

One of our chief problems is personnel. This has become increasingly acute since Korea, with the expansion of our armed forces, and has necessitated planning for the medical and dental needs of the three services and at the same time assuring that a sound educational and training basis for the young men of this country in medicine and dentistry be not too greatly interrupted. You have all struggled with the problems of recall of reserves and utilization of Priority I, II and III groups, the

doctors under the regular draft and then the doctors' draft (Public Law 779). All of us hope that the doctors' draft may elapse at its normal expiration on June 30, 1955. With the expiration of the doctor draft, some changes of the regular draft law will be in order to permit the orderly call-up and effective utilization of physicians obligated under this legislation.

The Health Resources Advisory or Rusk Committee cooperates both with the Selective Service and with our office, and it has been due chiefly to the recommendation of this committee that the ratio of doctors in the armed forces has been reduced to its present low levels. The services have cooperated admirably in the readjustments necessary to meet the ratio that now stands at 3.26 doctors per thousand troop strength for the Navy, 3.0 for the Army and 2.9 for the Air Force. This adjustment has not been easy in view of the increased size of the armed services and the all too short two-year period of service for doctors and dentists; also with the increasing numbers in the armed services a vastly greater load of dependents has required care, to say nothing of the federal workers and their families from other departments of the government in overseas areas.

The solution to the problem of adequate medical staffing has not been helped by the decision during World War II to start all internships and residencies on July 1 of each year. This has produced a difficult enough situation in

Read at the 104th Annual Session of the Medical Association of Georgia, Macon, May 2-5, 1954.

civilian hospitals, but doubly so in the armed forces. With the two-year obligatory service requirement as it is, there is also the added factor that by far the greatest requirement for doctors and dentists in the armed forces come in alternate years. The drastic turnover makes for inefficiency in the services—with the large number of losses combined with the equally large number of gains into the service at approximately the same time.

We have a very limited supply of professional and scientific manpower with little likelihood of considerable increase for another five years. What are the basic reasons for these shortages?

1. During the decade of 1930's, there was a sharply decreasing birthrate.

2. Since 1940 the birthrate has increased equally sharply, if not more so.

3. The span of life has been extended over the past 50 years so that the average life expectancy is now 67 years.

4. Combining the above actualities, we find that we have an increased number of infants and children in early years of life and more aged in the later years that require medical care, and at the same time due to the low birthrate of the 1930's the productive young adult working group is perforce limited and without possibility of expansion until about 1958 or 1959.

5. New and great industries have been added to our civilization with none dropping out; television, electronics, etc.

6. Finally, due to the extraordinary discoveries during the past decade, there has been an enormous increase in the demand for physicists, chemists and workers in the automotive and airplane industries.

Added to these may be considered the fact that "since 1900 the number of men and women who work in the sciences and the professions has been growing almost twice as fast as our total population," and between 1949 and 1952 our expenditures for research and development doubled to a present cost of about 3.5 billion for the employment of 160,000 scientists and engineers; the federal government provides about three fifths of this money. Also, you will remember that in 1952 the President appointed a commission to study the health needs of the nation and its report emphasized the "seriousness of current shortages and estimated that by 1960 the country will lack from 22,500 to 45,000 doctors." With our higher standards of health and growing national income the demand for medical services has been increased,

so much so that the limited capacities of our medical schools have not been able to keep up with the demand. This adjustment cannot be made rapidly as you very well realize. Consider for example the plight of many of our state and municipal institutions, our public health services, their need for medical personnel and their inability to meet the competition of industry, hospital and medical school expansion and the private practice of medicine.

I have given you some of the factors underlying our present shortages in professional and scientific personnel and will try to point out how we may prevent or meet them. In view of the present situation it seems likely that governmental expenditures for research and development will remain on a high level, and at the same time there is little likelihood of any decrease in the numbers in the armed forces. Therefore, with the given supply of active young adults the best we can do is:

1. "To try to alter the distribution of young men and women among fields of scientific and professional study so as to increase the numbers preparing for work in the fields where shortages are anticipated; and

2. "To try to expand the size of the total college population so that more young men of ability will be educated in each field;"

3. Better utilize any given group.

All of these take time. The immediate growth is by way of the first and last suggestions, and this applies particularly to the armed services where we must make every effort to improve the distribution and utilization of our limited available supply of scientific and professional personnel. At the same time the Department of Defense has taken a further step by preparing a bill to provide a certain number of scholarships for medical and dental students, with a requirement attached for service as repayment of the scholarship. Selection of candidates for these scholarships will be left entirely to the deans of medical schools in coordination with the Department of Defense. We hope in this way to attract a certain number of young men into the service for three or more years. This will provide the government with a much more useful officer than the two year doctor coming in under the draft. The minimum service required is three years. If a given candidate receives a scholarship throughout his medical course, then he will serve four years. This supplements but in no

way interferes with the opportunities for residency training already present in the armed forces on a year to year basis.

With the probable expiration of the Doctors' Draft in June 1955, it occurred to us that we might begin to plan for a more considered and considerate type of induction into the medical services than heretofore. We have all had experience with the "matching plan" in hospitals over the past three years. It occurred to us that perhaps a similar plan might be utilized by Selective Service and the armed services. We, therefore, sent out a sample questionnaire on January 6 of this year and by the end of the month had received 1,800 replies from 42 medical schools. These results were reported to the Council on Medical Education in Chicago early in February. We asked six questions: the first three had to do with the branch of service preferred and in the second three, the fourth year student expressed his preference as to whether he desired service immediately following internship, after internship plus one additional year of training or after full residency training. The answers were as follows: 37 per cent preferred the Navy; 36 per cent—Air Force; 27 per cent the Army; and the balance undecided. As to time of entrance into service, choices were: after internship—39 per cent; after internship plus one year of training—15 per cent; after residency—46 per cent.

Considerable interest was expressed both on the part of the students themselves and of the deans of the medical and dental schools, who asked if we could not put this plan into effect at once in view of the fact that the graduating classes in the medical schools of 1954 will be finishing their internship just as the Doctors' Draft is expiring in 1955. Therefore, in conjunction with Selective Service, cards were developed applicable both to medical and dental schools and were distributed to all the schools prior to April 1 of this year, with the request that the dental schools return their cards before May 1 and the medical schools by May 15. Inasmuch as this year's class of dental students becomes liable for service on July 1, it is important that we process our information cards as early as possible so as to permit entrance of these recent dental graduates into the service with as little delay as possible. As to the medical group, we shall have approximately a year to separate and classify them before they will be liable for duty in the armed forces. Because of the added security requirements, however, it now takes 90

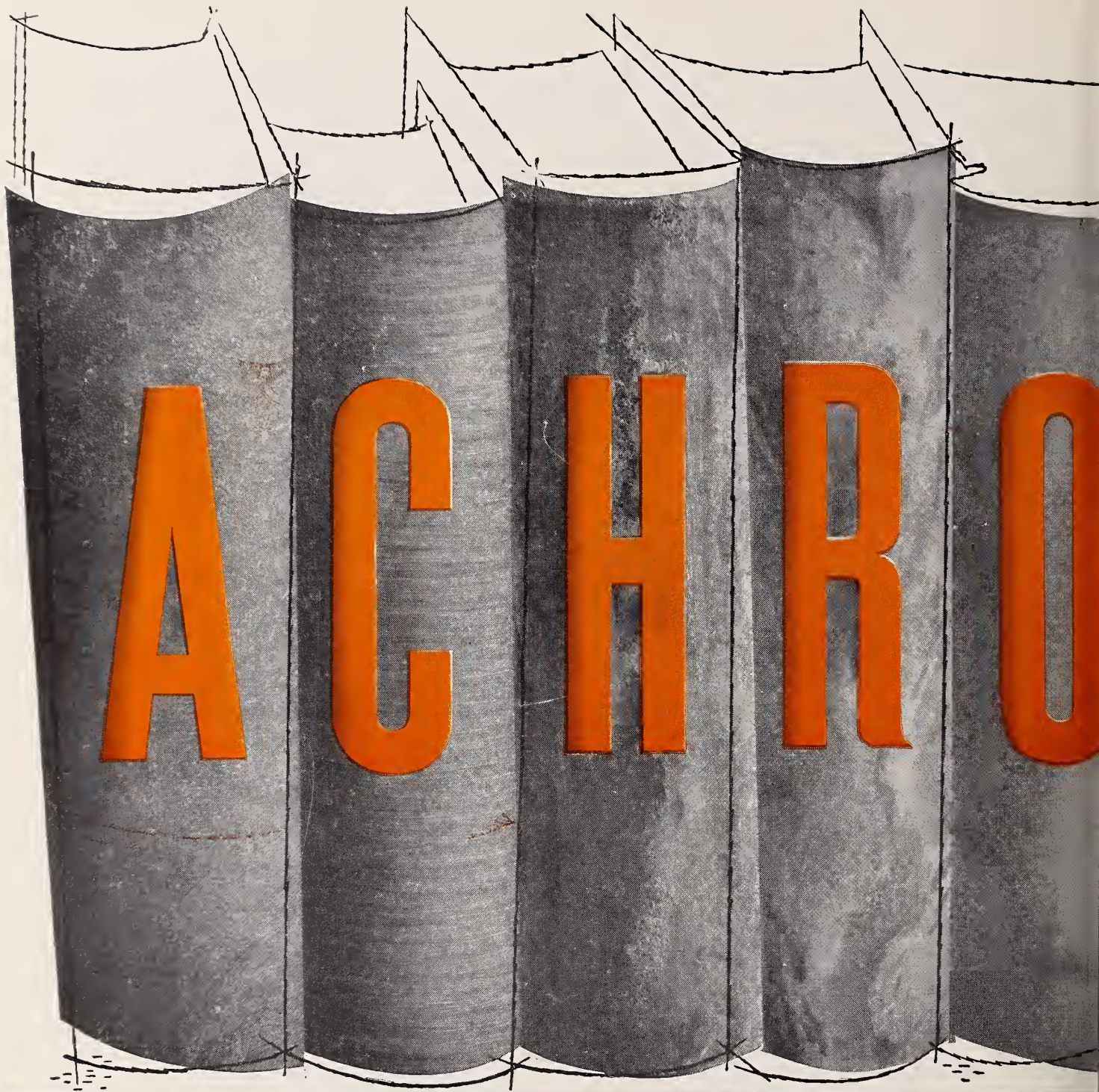
days to clear each individual before he is acceptable for a commission. All of this is of the utmost importance to the student, whether he be medical or dental, because of the need for him to make his own plans. Approximately one third of our medical student body is in debt at the time of graduation, averaging about \$2,500, but running all the way to \$10,000. They must have continued means of livelihood whether through pay by the services after internship or by some hospital or industry. Furthermore, a large proportion of our graduates today are married. Most of the wives are working and some have children, which again enters into the planning for the immediate future.

By utilization of the information received in the "matching plan," those desiring early service will be assured of it. This reduces the number that must be considered by Selective Service and the armed forces for deferment for further training. It now seems probable that we shall not have to go below the second choice either for branch of service or time of entry. These attainments in themselves are highly desirable, because it will become evident to the students that they are being considered as individuals, and as a result they will be better motivated and happier during their tour of duty.

As another step in advance, Selective Service, working with the Rusk Committee and this office, has agreed to permit voluntary applications for commission in the Reserve after July 1 of this year. Through a joint committee of the three services working in conjunction with this office, we in turn will allocate this group to the services as far as possible according to the preference of the individual, and at the same time prevent too much of a stockpile in any one of the services.

At the present time the services have about one third or less in the regular corps and two thirds reserve officers, which is not a healthy condition and should be reversed. With the aid of a scholarship bill such as I have described, the residency training offered by the services for limited numbers, a change in our induction policy and the freedom with which medical school graduates may volunteer for the Reserve during their internship, we hope the medical careers in the services or the desire for extended active duty for varied periods may be enhanced.

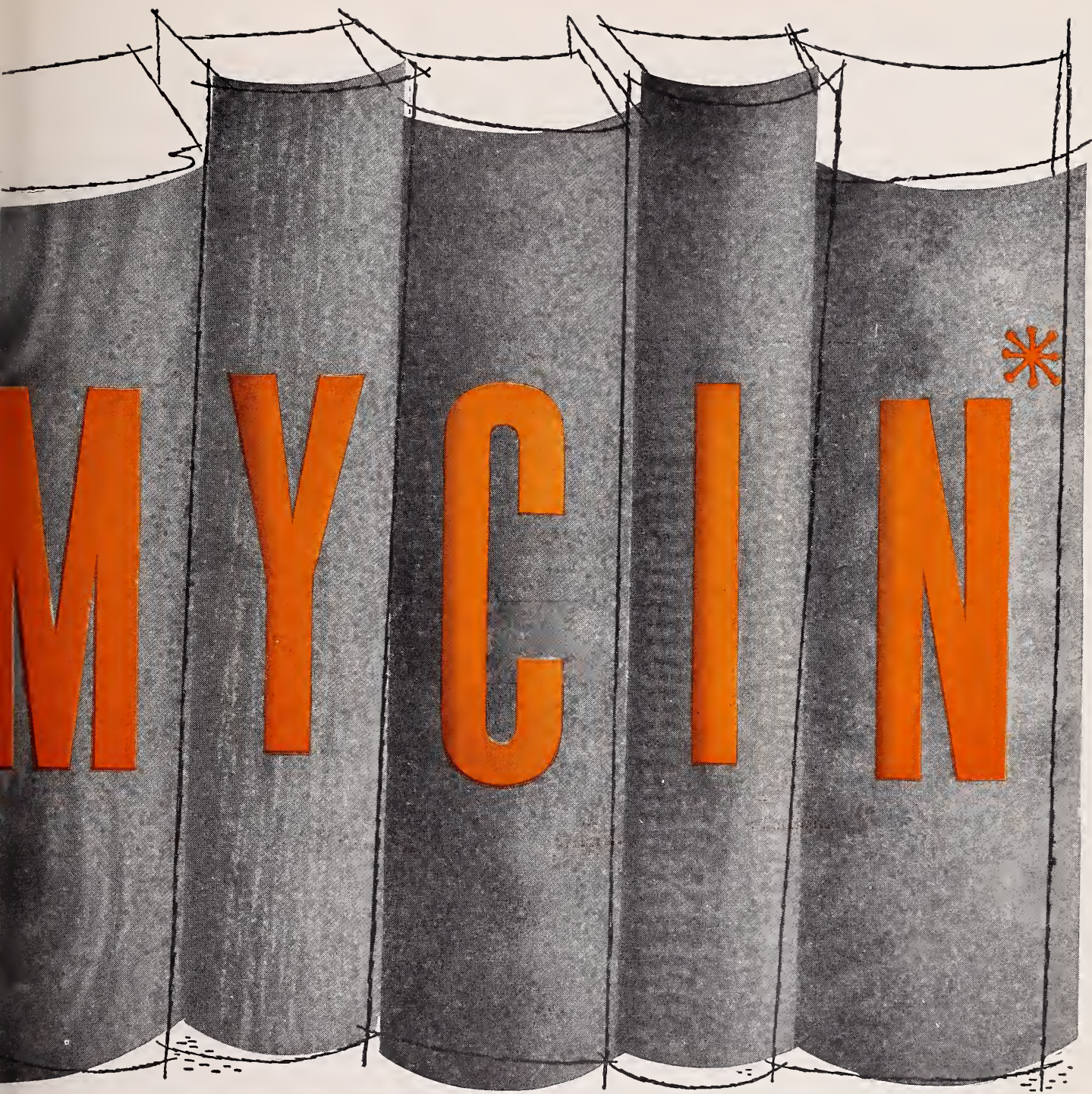
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The Control of Cardiac Edema

SIMONE BROCATO, M.D., Columbus, Ga.

THE CONTROL of abnormal salt and water retention accompanying congestive heart failure involves the judicious use of digitalis, a low sodium diet and parenteral or oral diuretic agents. Dramatic results may be attained with correction of anemia, Beri-Beri, arterio-venous aneurysms, hypo- and hyperthyroidism and congenital defects amenable to surgical therapy.

Digitalis or one of the glycosides is essential for the control of most types of cardiac failure since its action is more specific for the heart. One must familiarize himself with the pharmacological actions of the drugs in order to know which pathophysiological types of heart disease might respond. Failure due to tricuspid or tight mitral stenosis, constrictive pericarditis, chronic lung disease, active myocarditis and those called the "high output type" (i.e., anemia, Beri-Beri, arteriovenous fistulas, etc.) may not be improved. *That an arbitrary dosage will not suffice cannot be too strongly emphasized.* Each patient must be individualized and given adequate initial therapy until the desired effect is produced or until toxicity appears. Many patients with cardiac decompensation will attain relative homeostasis on rest and sedation; the physician is thereby led to believe that adequate digitalis has been administered (or is not needed) only to find that dyspnea and edema return with resumption of activity.

The daily maintenance dose which must be administered in chronic failure varies from time to time and periodic adjustment is necessary, depending upon improvement or progression of the primary disease, ensuing complications, intercurrent infections and illnesses. Occasionally "redigitalization" is needed after long periods of treatment.

Auricular fibrillation, multiple premature beats (particularly multifocal) and other arrhythmias

may necessitate the use of Quinidine, Pronestyl® or other drugs, if digitalis alone does not correct them or, on the other hand, is not responsible for them.

Since the abnormal fluid accumulation is due to the improper excretion of salts, the avoidance of dietary sodium is beneficial. The need for this too must be assayed; one should hesitate to enforce a rigid salt-free regime on every patient. Initially, the use of salt at the table and foods such as crackers, breakfast meats, ham, canned soups, etc., should be curtailed. As a further step, seasoning used during cooking, together with bread, butter and cheese containing salt are given up. Diet lists should be provided for patients requiring strict abstinence.

The next step involves use of diuretic agents, chiefly the organic mercurials administered parenterally. Unless the situation is urgent, these are best reserved until digitalization has been achieved, for adequate diuresis frequently follows their use altering the clinical findings and, perhaps, masking the need for digitalis. The choice of many commercial products depends on the route of administration required. Those containing theophylline, such as mersalyl (Salyrgan®), theophylline, meralluride with theophylline (Mercuhydrin®), and mercapto-merin sodium (Thiomerin®) are much less irritating when used intramuscularly. Of these, meralluride with theophylline seems to be the most satisfactory. Some physicians combine them with small amounts of one per cent procaine in order to diminish the local reaction. Thiomerin® is the least irritating for subcutaneous use. The *intravenous* injection of theophylline-containing compounds, however, may produce adverse effects, and, therefore, preparations which *do not include* this drug, such as mersalyl and mercapto-merin sodium, are much more satisfactory; but they also must be given cautiously.

All of these compounds may produce sensitivity reactions, renal damage and electrolyte imbalance; hence, it is expedient to begin with a test dose of one half to one cc. intramuscularly, depending upon the severity of the failure and the renal status. In this regard it is well to remember that moderate albuminuria, increased red and white cells and casts are frequently found in the urine of patients with edema; in addition, some uremia may be present. This often is secondary to the failure and should not be interpreted as a contra-indication to diuretic therapy. The presence of poor urinary concentration and gross uremia deserve careful analysis, however. The amount needed depends on the clinical problem, and the efficacy of digitalis and the low salt diet. Many patients require only an occasional injection, whereas two or three per week are needed for others. Small doses such as one cc. three times weekly, when this amount suffices, are better than larger doses at more lengthy intervals (i.e., three cc. once weekly). Of course in emergencies one may administer two cc. or more intravenously.

Ammonium chloride in sufficient amounts produces acidosis and therefore promotes diuresis and the loss of sodium through excretion of the acid products. In addition, it potentiates the action of the mercurials, although the exact mechanism is not known. These large amounts may be more conveniently given by using one gram tablets (Lilly, Brewer). Many patients would rather take liquids than so many pills, and a 20 per cent solution compounded in a vehicle of the physician's choice may be well tolerated. Continuous therapy with ammonium chloride results in a loss of efficacy, so treatment should be interrupted at intervals of two to four days for four or five days. If mercurials are also required they should be injected towards the end of each period of ammonium chloride administration in order to produce the synergistic effect.

Mercumatilin (Cumertilin®) is a relatively new oral mercurial diuretic; it rarely produces side effects and when used properly obviates the need for intensive parenteral therapy in many patients. One to three tablets, three times daily, for three or four days per week (observing the precautions outlined previously) may be beneficial. Chlormerodrin (Neohydrin®) is also used by some. Acetamizazole (Diamox®), a non-mercurial diuretic, produces acidosis by inhibiting carbonic

anhydrase in the kidney, but its value is questionable.

It has recently been emphasized that intensive diuretic therapy (and indeed minimal treatment in rare instances) combined with salt restriction may result in excessive loss of sodium, potassium and chlorides and other elements producing variations of the "low salt syndrome." When relatively large amounts of chlorides and potassium are excreted, *hypochloremic alkalosis* may appear. Another variety is associated with depletion of sodium chloride in the extra-cellular fluid, accompanied either by *dehydration* or *excessive fluid retention*. The phenomenon of *post-diuretic redigitalization* simulating digitalis overdosage is quite probably due to hypopotassemia in many cases rather than reabsorption of digitalis from the tissue fluids.¹ In general, these syndromes are heralded by weakness, anorexia, apathy, vomiting, mental confusion, thirst, peripheral circulatory collapse and/or other manifestations which are frequently erroneously attributed to progressive disease, embolic phenomenon or infections. If the resistant edema (or reaccumulation) is due to electrolyte imbalance rather than one of these entities, intensification of diuretic administration may be disastrous.

There are many ways to guard against the "low salt" complications. Since maximum diuresis occurs in the first 24 hours after injections, an office weight-check may be done at the end of this period; else, the more dependable patient may phone in his urine output for that time. A lack of the usual response should be regarded with suspicion, and further therapy must be given with utmost caution. Secondly, in hot Georgian summers the loss of sodium and water in sweat results in less need for rigid salt regimes and intensive diuresis. Patients requiring frequent mercurial injections should receive intermittent ammonium chloride therapy as outlined; this increases the fluid and sodium excretion and, in addition, prevents the excessive loss of body chlorides. Four or five grams of potassium chloride administered on the day before and after injections prevents the effects of hypopotassemia. As an additional safeguard, urinary chloride excretion may be checked very simply in the office by the Uclotest® reagents or the Fantus test.² If a low urinary chloride concentration is demonstrated (less than three grams per liter) hypochloremia may be present. In order not to produce adverse effects, patients requiring intensive parenteral mercurial therapy

should receive ammonium chloride rather than the oral mercurials.

The self-administration of Thiomerin® at home has been very unsatisfactory in the author's experience. Patients with enough edema to justify such a step are usually not completely digitalized, are not restricting salt enough, or they are sick enough to require constant personal checking by the physician at which times the injections may be given under supervision.

As a final resort, if the edema does not respond to carefully supervised treatment as outlined above, the use of the newer Southey-Leech tubes may

be most gratifying. If used in relatively acute cases of soft edema not accompanied by tissue fibrosis, large amounts of fluids may be lost.

1509 Fourth Avenue

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"Dog Tag" for Pregnant Women

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WITH THE VAST majority of labors taking place in hospitals, especially in the urban areas in the United States, procedures which facilitate the management, often of an emergency nature, should be welcomed. Probably there are fatalities or near fatalities occurring because of lack of immediate information concerning the patient in question. Many of the pertinent facts of her condition could easily be recorded on a modified dog tag and applied by a neck or arm type string or chain for the patient entering the hospital in labor. Such is especially valuable to the fetus in regard to the Rh factor or the presentation and to both mother and fetus in respect

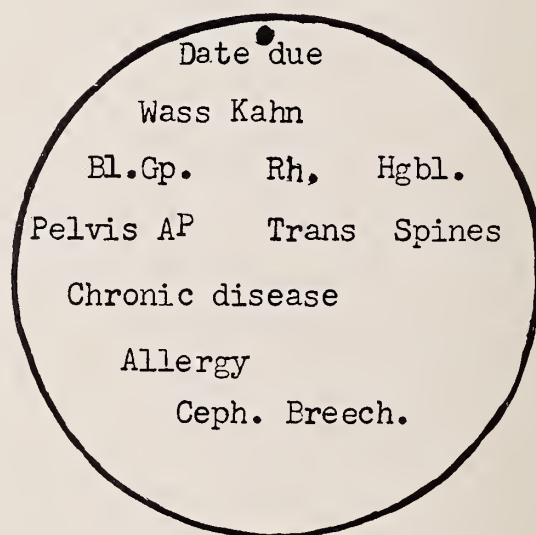


Fig. 1. One face of tag for pregnant women entering the hospital. The opposite carries name, age, para and gravida.

to allergies in avoiding the use of certain drugs. It is important in chronic diseases as diabetes, tuberculosis, cardiac and renal disorders. Each of these could be identified by a colored tag.

It is impossible for the busy obstetrician to keep all of the facts in mind, and certainly the hospital staff would welcome such a simple reminder for the patient. It is possible that the information on the tag may save the patient's life and in addition afford the pediatrician indispensable knowledge in care of the newborn infant.

Medical College of Georgia

Current Treatment of Otitis Media

THE PAST DECADE and a half has witnessed dramatic changes in the concepts of treatment of bacterial diseases, particularly those causing inflammation of the middle ear and its environs, including labyrinth and cochlea. It is important to realize that in otitis media, not only is the middle ear filled with pus and fluid, but also the mucous membrane of the mastoid cells as well as the Eustachian tube itself are involved in the process of inflammation. No doubt the use of proper antibiotics during severe bacterial infections of the upper respiratory tract has reduced the incidence of suppurative otitis media and its complications. This has led many physicians to an unwarranted complacency in its treatment and a disregard for the important procedures of thorough history taking, meticulous examination of the nose, sinuses, nasopharynx and ears, careful testing of the patient's hearing and consideration of the sound surgical principle of either paracentesis or myringotomy, or both.

One of the first dictums that a young physician learns in medical school and one that seems most easily forgotten, especially when otitis media presents itself is: "Where there is pus present, *drain it*." Antibiotics and chemotherapeutic agents will limit the spread of infection, but they cannot drain pus. This latter procedure depends upon the individual physician, his training and conception of ear disease. Rutherford³ thus summarized the problem:

"Even in large teaching centers, interns and residents are not being taught the anatomy and physiology of the middle ear or a knowledge of the pathologic processes which may occur within it . . . (This) has led to a state where the younger physicians do not know the art of cleansing the ear canals, of observing and recognizing the changes in the tympanic membrane . . . or how to do a myringotomy. In fact, some of these young men and women have been taught that myringotomy is not only an unnecessary procedure but one to be avoided because it injures and scars the tympanic membrane, although spontaneous rupture of the drum under antibiotic therapy is not

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considered harmful. They do not differentiate between suppurative and nonsuppurative acute otitis media; the treatment is always one of the antibiotic drugs without regard to the bacteriology involved. If one drug does not bring results, another antibiotic is resorted to, or possibly 'combined therapy', the shotgun method, is used."

The physician treating ear disease in children as well as in adults has a dual responsibility to his patients: the more important is to preserve hearing; the second, of equal if not paramount importance, is to prevent mastoiditis and chronicity and hazardous complications, both intra- and extracranial. The dictum "The cause of chronic otitis media is neglect" is more true today than it was 15 years ago because chronicity is more easily prevented today. To quote Rutherford⁴ again:

"The practice, widely accepted among pediatricians and general practitioners, of allowing the eardrum to rupture when and where it will, shows an appalling ignorance of the dangers of the chronically discharging ear. The site of the perforation has a bearing upon the prognosis, and while many drums rupture where healing is likely to occur, others may perforate in Shrapnell's membrane leading to a chronic suppuration in the attic with all its dangers of extension of the disease to the labyrinth, lateral sinus, facial nerve and meninges."

Probably the most common error in the treatment of acute otitis media is undertreatment with antibiotics without myringotomy. Undertreatment will also lead to a superinfection, often by organisms that develop resistance to the antibiotic during the course of use; organisms that were considered non-pathogenic in the days before antibiotic therapy. There have been many recent instances of individuals who become infected with organisms resistant to the usual antibiotics, and successful treatment has been effected only by use of the smear, culture and sensitivity testing which

should be routine in any infection.

The only indication for a myringotomy should be a reddened and bulging eardrum with loss of the normal landmarks and a concomitant hearing loss. Paracentesis of the drum will be discussed later. As to myringotomy: this is usually performed under general anesthesia in the hospital, either emergency clinic or regular operating room. Sterile technique is essential, particularly that of the external ear canal of the side involved. Since the individual is usually in pain, cleansing of the canal is postponed until the anesthetic has taken effect; then with alcohol or Zephiran® the canal and drum are cleaned gently of detritus. The latter is nearly always the result of seepage of serum through the intact but bulging drum resulting in a lowgrade external otitis often due to yeast such as monilia. The following case will illustrate:

CASE REPORT:

A six-year-old child was brought in by her mother after having two days treatment of a "running ear" with penicillin. The local pediatrician told the mother that the drum was already ruptured and that the antibiotic would clear it right up. For two nights the child was restless, complaining still of earache, and the canal indeed had a lot of "pus" in it.

After the child was asleep on the table, thorough cleansing of the involved canal revealed that the "pus" was merely detritus, as mentioned above, and that the drum was still intact although it was very red, bulging and tender. Microscopic examination of the "pus" revealed the presence of monilia. A vertical incision was made in the posterior portion of the drum and about five cc. of purulent exudate was aspirated. Upon culture and sensitivity testing, the causative organism was shown to be a *Staphylococcus aureus*, highly resistant to penicillin, but very sensitive to aureomycin. In five days the drum was healed, discharge stopped and the landmarks were returning well, with normal hearing.

The advent of the Senturia middle ear aspirator and the Trowbridge and Gottschalk aspirators has greatly facilitated the management of ear disease, since a sterile spinal needle (usually No. 19) can be introduced through the cleaned eardrum, and the middle ear contents can be evacuated into a sterile container, from which cultures and other cytologic studies can be made at leisure. Then with a sharp knife, the tiny hole in the drum caused by the spinal needle is extended. The Brunnings otoscope is used to aspirate both pus and fluid from the middle ear regions, to force canal air through the incised membrane, to evacuate the Eustachian tube of various cellular detritus and inspissated secretions, and to maintain its patency. If the Eustachian tube were patent to begin with, the middle ear pus would have drained down this way from the start and there would not have resulted a red, painful and bulging ear drum.

A red, bulging eardrum is an emergency, and one cannot merely look at it and by some method of clairvoyance determine the organism causing

the infection; much less can one, by the same token, determine to which of the many antibiotics and chemotherapeutic agents available the causative organism is sensitive.

From past experience it has been determined that several of the broad spectrum antibiotics are especially useful against the usual organisms grown in culture. These include: tetracycline, oxytetracycline, chlortetracycline and chloramphenicol as well as erythromycin. This last drug, also known under the trade names Ilotycin® and Erythrocin®, is bactericidal.¹ Out of 100 successive cases of otitis media in which myringotomy was performed with smear, culture and sensitivities testing, both disc and in vitro, penicillin was found effective in only three cases. There is no harm, after the specimen has been taken, in using one of the antibiotics mentioned above. If, after 18 to 24 hours, in some cases (e.g. *Proteus*) 48 hours, the sensitivity results are different, the drug may be changed, but usually the original choice has proved effective. One might well ask, "If *such and such* a drug is useful, why not use it and not do a myringotomy?" This blissful state of ignorance still does not identify the causative organism, nor does it get rid of the thick, tenacious secretions that are the cause of so much deafness, particularly in the young. The following case will illustrate:

CASE REPORT

A six-year-old female, a physician's child, had been under the care of her local pediatrician for at least six months for repeated attacks of tonsillitis and deafness. The drug of choice in the case was penicillin, sulfa or a combination of penicillin and streptomycin. The mother noted that the child was becoming listless and hard of hearing. She called it to the attention of her pediatrician who shrugged it off as probably "a little wax in the ears."

When the child was brought to the office for removal of the cerumen she was accompanied by her father who was surprised to confirm the absence of wax. In its place was a bulging, unruptured eardrum that was the color of wax; in point of fact, the diagnosis was a chronic serous otitis media. The process of secretion and bulging had been masked by the previous therapy to the detriment of the child's rapport with her surroundings.

At operation, myringotomy with culture, and with the father present, the drum was incised and about five cc. of thick, stringy, tenacious sero-mucinous fluid was removed. The child was hearing much better by the time she arrived home post-op., and in a few days the drum was healed.

The bacteriology report was a "scant growth" of pneumococcus most sensitive to erythromycin.

Bacteriology

In the last 100 consecutive cases of otitis media, there was not a single instance of the Beta-hemolytic streptococcus; the hemolytic staphylococcus and the pneumococcus predominated, with several cases of primary infection with *Strep. viridans* and *Proteus*. This is significant as recent authors report that up to 80 per cent of the hemolytic

staphylococcal strains are resistant to penicillin and are becoming increasingly so to the broad spectrum antibiotics. Thus, there is all the more reason for careful history and thorough examination, in addition to myringotomy with culture and sensitivities. Since the middle ear and mastoid spaces are closed, particularly when the Eustachian tube is blocked, the vacuum resulting leads to extravasation of serum and the so-called "serous" otitis. This fluid, high in protein, is an ideal medium for growth of invading bacteria, chiefly via the blood stream. Therefore it is imperative to do anaerobic cultures in addition to the usual blood agar and brain-heart infusion cultures. In fact, there is one organism, *Bacterioides fungiliformis*, common in chronic ear disease, meningitis, and brain abscess, that is grown *only* anaerobically.²

Method

There are two methods of opening the eardrum, both of which when properly performed do not lead to a permanent perforation. Usually it is the paras that are poorly done and performed too late that result in continued openings in the drum. Also when the drum ruptures by itself, it does so either centrally or in the thinnest portion of the drum, Shrapnell's membrane, and perforation of the latter site commonly results in a permanent perforation. The eardrum may be opened as many times as indicated; often as many as six to ten or more punctures. In fact it is hard to keep a drum open; the use of cortisone and similar drugs to limit fibroblastic proliferation, at the same time "covering" the infection with the proper antibiotic, has been suggested as a method of maintaining patency of the eardrum until the infection is under control and the discharge has stopped.

Paracentesis tympani is the simple stab perforation of the drum, either with a sterile needle (spinal No. 19) or the diamond-headed knife. It is usually performed in the lower portion of the drum to facilitate removal of secretions. A contrapuncture in another portion of the drum may aid in this, much as two holes in the top of a can of milk or beer. Gentle suction either with a pipette or machine will collect enough for culture and sensitivities. Then inflation of the middle ear with the Politzer method or eustachian catheterization will force more fluid into the canal. The Bruening's otoscope can facilitate matters also. The patient is usually one with a "serous" or catarrhal otitis, and in this condition the drum is relatively insensitive. He is told the pain is similar to that when a blood specimen is drawn from an antecubital vein; usually the patient remarks that the

pain was hardly noticeable! The return of hearing is dramatic, and great relief is experienced.

Myringotomy is the wider incision of a drum membrane, done with a lance-shaped knife, usually beginning in the inferior portion of the drum and carried posteriorly upwards to the 10 o'clock or two o'clock position depending on whether the right or left drum is under consideration. As a refinement in technique the direction of the myringotomy incision may be reversed and carried from above downwards. As the central portions of the drum are nearer the promontory of the middle ear, there is less likelihood of damage to this region of engorged vessels with resultant hemorrhage when the arc of incision begins superiorly and is carried inferiorly, and thus away from the promontory; the inferior portion of the drum being farther away from the medial wall of the middle ear space than is the upper central part of the drum. Myringotomy is most frequently done for the acute, painful otitis media, and best performed under general anesthesia both for consideration of the patient and convenience of the surgeon, who can take his time in making an adequate opening to drain as much pus as possible and empty the eustachian tube without frightening the patient. Particularly is this to be done in the case of children. Some surgeons like to use anesthetic drops in the canal, but even here the features of the drum are likely to be obscured. It is hard to clean the canal and get rid of the solution, especially when one is confronted by a frightened child in pain struggling in the arms of a sympathetic nurse or mother. The danger of greater damage to the inner ear and environs is increased when the child is moving its head. Therefore for all concerned, it is best to use a general anesthetic, after the usual precautions have been taken. In a child with serous otitis media and associated retraction of the drum it is possible, though not recommended, to do a paracentesis without frightening him.

Discussion

All of these procedures result to some degree in scarring the drum, but the advantages of actually being able to find out the causative organism and the proper drug to combat the infection, as well as to relieve pain, lower temperature, make the patient comfortable and get rid of thickened secretions that lead to adhesions and varying degrees of deafness, far outweigh the doubtful advice to "wait and see" what will happen. Even with the most readily available antibiotic, a period of several days is needed to limit the spread of in-

fection, and in the meantime a blissful state of ignorance remains as to the nature of the infection and often the antibiotic chosen has absolutely no effect whatsoever; e.g. penicillin. Any parent or physician that will allow a child to suffer even one night of pain when an adequately performed opening or "lancing" of the eardrum can bring relief is callous indeed.

A further advantage to myringotomy and removal of the middle ear contents is the frequent finding that one is unable to blow canal air through the eustachian tube: when the tip of the aspirator is passed through the incision in the drum in the direction of the orifice, i.e. anteriorly, a small or even relatively large fibrin clot can be suctioned, often adhering to the tip so that it can be removed in toto from its obstructing place. When this has been accomplished, it becomes easy to aerate the formerly blocked eustachian tube and thus be satisfied that adequate drainage has been established. Failure to remove this clot results in continued suppuration and chronicity. When an acute otitis media fails to clear up in a week to 10 days, the use of varidase or similar enzymatic dissolving agents would be indicated.

Assuming that antibiotics alone are used: After the spread of infection has been limited, what happens to the secretions? If they are not removed by opening of the drum, they either remain and inspissate, or they wait for the eustachian tube, that has been blocked from the first, to reopen and drain. The danger in following this course of action is that adhesions form and pockets of pus are thus isolated, chiefly in the attic. The adhesions lead to varying degrees of deafness, and the pockets often maintain a focus of potential infection by preventing access of the antibiotic to the enclosed bacteria. Otitis media can thus occur from a few to many years later, particularly in the growing child, when, due to slight changes in the middle ear dimensions commensurate with normal growth, such a pocket of pus may rupture and start the train of infection over again.

From the severity of the infection, usually pneumococcal, some cases of otitis media are "chronic" from the start. They progress, in spite of opening and specific antibiotic therapy, to chronicity and even mastoid cell destruction, necessitating operation. One cannot tell in advance which cases will turn into this avenue, therefore it is imperative that one know from the start of any acute otitis media, the bacterial adversary and be prepared to cope with it and its sequellae in all its

potential manifestations. Many are the children as well as adults who present well-healed drums and in whom the scarring is so minimal as to be seen only with magnification.

A word as to catarrhal otitis in which there is slight pain, minimal bulging of the drum with reddening superiorly, with fairly normal light reflex and slight retraction anteriorly: This patient is usually a child who has a mild "cold" and says the ear "hurts". If the previous few nights have been fairly restful with only occasional "picking" at the involved ear or ears and "crying-out" minimal, with no or low-grade fever, and in addition if the physician has been taking routine cultures and sensitivities on his patients . . . then, and only then, is he warranted in using the most effective antibiotic, in one recent series this was Ilotycin®, without opening the drum. To allay pain and provide heat to the drum Auralgan® is indicated at the same time. Nasal drops or spray is helpful only if the blockage is at this end of the eustachian tube and not at the middle ear orifice. Several recent cases thus have been treated; it is dangerous so to handle a "red-hot," acute, painful otitis media. With modern advances in bacteriology and in the handling of ear infection, it is folly to be ignorant when it is possible to know what is going on.

When the case presents as causative organism a staphylococcus, the advantages of using autogenous vaccine should be considered. This has proved very useful in sinusitis, and in a few recent cases of otitis media it has been decisive in healing.

Before the advent of chemotherapeutic agents and the antibiotics, many ears healed well with only myringotomy. Therefore the modern physician is wise to allow the patient time to develop his own antibodies and "resistance" by refraining from too quick administration of these agents. One sees in routine office practice and clinic work more and more patients who, fortunately, have never had these therapeutic agents, but who unfortunately become infected with strains of bacteria resistant to most chemotherapeutic and antibiotic agents. The shot-gun method of treating infections is mentioned only to be condemned: cultures with anerobic handling and sensitivity testing in cases of otitis media is the only way to be sure of what one is dealing with in such cases. Careful inquiry as to previous medication and skin rashes, edema, urticaria and joint pains is necessary to avoid sensitizing the patient to these agents against

a time when they become infected with a resistant organism and will really need an effective drug. The routine practice of giving a "shot" of penicillin for a "cold" is a case in point.

Once drainage has been established no irrigation of the canal is required. Most parents are intelligent enough to follow the simple directions to use a clean, dry, cotton-tipped applicator to wipe out the meatus and another one to apply vaseline to the area and lobe of the ear. This prevents "caking" of blood and pus on the skin of this region and cheek. In only a few instances will the physician have to use suction and the Bruenning's otoscope to facilitate drainage of pus from an already incised drum. It goes almost without saying that a properly performed adeno-tonsillectomy with thorough cleaning out of the nasopharynx, including the fossae and recesses of Rosenmuller, will go a long way toward decreasing the incidence of ear disease, but it will not prevent otitis media in every case.

Summary

The condition known as otitis media, either acute, sub-acute or chronic, or a "rising" in the ear, is not merely an inflammation of the middle ear space alone; adjacent structures and mucous membrane are also involved in the infectious process. When necrosis of bone supervenes, mastoidectomy, simple, radical or modified radical as the case warrants, is indicated; otherwise, incision of the drum, drainage of pus and specific treatment usually suffices.

Whether in a given case an ear becomes infected or not, or goes on to chronicity, is determined by the set of circumstances converging in time on that particular ear; not a few of these involve the patient's own "resistance", previous ear infections, sensitivity to drugs used to combat the infection, the antibody response and titre, the kind and virulence of the invading organism and its sensitivity to drugs. The changes and variables are so many and the danger of mishandling a case so great that it behooves the physician to avail himself of the most modern thought and methods to bring about the desired result; namely, control of pain, prompt healing, prevention of chronicity and preservation of hearing, especially in children.

He can do this by draining pus when found, using sterile technique, smear studies, culturing and obtaining sensitivity studies and treating specifically with the most effective antibiotic or chemotherapeutic agent available.

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The AMA Goes to Miami

Sunny skies, swaying palms and broad sandy beaches are but a few of the attractions Miami offers physicians and their wives planning to attend AMA's eighth annual Clinical Meeting Nov. 29-Dec. 2. An excellent scientific program—including lectures, exhibits, motion pictures and color television—plus a large array of technical exhibits have been lined up for AMA visitors.

This year's program stresses the practical everyday problems which face the general practitioner. The lecture program will include subjects of broad interest in the fields of medicine, surgery, pediatrics, neuropsychiatry, and obstetrics and gynecology. Motion pictures will be shown continu-

ously, and a special evening film program has been arranged. Bringing the operating room directly into the lecture hall, color television programs will originate from the Jackson Memorial Hospital. The Scientific Exhibit will feature about 80 exhibits, and demonstrators will be on duty throughout the week to answer physicians' questions.

Lectures, both the Technical and Scientific Exhibit, motion pictures and color television as well as registration will be housed at Dinner Key Auditorium. The McAllister Hotel has been selected as the headquarters for House of Delegates meetings.

Nongonococcal Urethritis:

Diagnosis and Treatment

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THE RECOGNITION of the gonococcus in 1879 by Neisser simplified the diagnosis of patients with urethral discharge for 60 years. Following his discovery, it was generally accepted that essentially all urethral discharges were due to gonococcal infection, and they were so treated. However, a few men would not support this view and published reports pointing out the high incidence of urethral discharges which were not caused by the gonococcus. With the advent of penicillin therapy, every physician was given an exact diagnostic tool with which he could readily differentiate between gonorrhea and nongonococcal urethritis (NGU). The immediate reaction was to consider many cases to be penicillin resistant gonorrhea. However, it soon became apparent that penicillin resistant gonorrhea did not exist, and the second reaction was that the incidence of NGU was enjoying a rapid increase. Figure 1, which lists the incidence of NGU in various clinics, illustrates that this increase is more apparent than real.

NGU is a more troublesome problem to the armed services than gonorrhea as it cannot be so readily cured, and the resulting time lost in visits to the dispensary is about 10 times as great due to lack of response to therapy. In civilian practice in this country, this situation is not so readily apparent, as the cases are spread diffusely among all the practitioners and not cared for in a central clinic, but it does exist.

Any discussion of NGU demands some tentative form of classification of urethral discharges, and Figure 2 represents our attempt at etiologic classification. We will concern ourselves with group "C" which is thought to be caused by microbiological agents and composes the majority of cases.

The clinical syndrome of urethritis is fairly uniform regardless of etiologic agent and presents

only minor variations in degree. As a result, the signs and symptoms are frequently not helpful in arriving at a diagnosis. The discharge varies from a frankly purulent nature to clear mucoid fluid. It is profuse or may be only a single drop of collected exudate present in the early morning before voiding. Approximately one third of the new cases of NGU have profuse, purulent discharge that grossly appears to be that of gonorrhea. On the other hand, essentially all cases of chronic recurrent NGU have mucopurulent or mucoid discharge. The symptoms do not parallel the nature of the discharge, but dysuria and smarting are most frequently seen associated with frankly purulent exudate. Approximately 75 per cent of the NGU cases point to the fossae navicularis as the site of their dysuria, the point of referred pain from the prostatic urethra. About one fifth of the cases complain of frequency and urgency; and a smaller group note a change in their urinary stream, pain in the pelvic region, excessive nocturnal emissions and mild priapism. Fever or signs of upper tract infection are rarely seen. However, a small percentage, when not treated early, develops acute epididymitis.

NGU has *not* been proved to be infectious in character nor venereal in origin. However, investigation of the recent activities of these patients

Povarnin	1895	25%
Mascall	1938	56%
Pelouze	1941	30%
McElligott	1942	30%
Willis	1942	62%
Arnold	1947	58%
Clark	1951	50%
McElligott	1951	42%
Ambrose	1952	43%

Fig. 1. This chart represents the percentage of NGU of all cases of urethritis examined in the clinics of the investigators named above.

Read before the Section on Urology at the 104 Annual Session of the Medical Association of Georgia, Macon, May 3, 1954.

Classification of Urethral Discharges

- I. Normal Secretions
 - A. Urethral
 - B. Prostatic and Seminal vesicular
- II. Abnormal Secretions or Exudates
 - A. Trauma
 - 1. Mechanical
 - a. Constant inspection
 - b. Masturbation
 - c. Stricture
 - d. Catheter
 - e. Foreign body
 - 2. Chemical
 - a. Prophylactic kits
 - b. Irrigation fluids
 - B. Sensitivity
 - 1. Foods
 - 2. Drugs
 - 3. Alcohol
 - C. Primarily due to Microbiological Agents
 - 1. Secondary to upper urinary tract infection
 - 2. Secondary to gonococcal urethritis
 - 3. Primary nongonococcal urethritis

Fig. 2. This chart is an attempt at classification of the various types of urethral discharges which are not due to the gonococcus.

reveals a group of sexually active young men. Over 90 per cent have had recent sexual exposure; and if there is an incubation period, it averages about 15 days with extremes of 24 hours to two months. The only correlation between the vaginal flora of the consort and the urethral flora of the patient appears to be coincidental occurrence of common organisms. The use of condom, the now discarded pro-kit, or prophylactic oral penicillin have no apparent influence on the incidence or course of this syndrome.

The possibility that this syndrome results from a focus of infection elsewhere in the body is not remote, and from 40 per cent to 60 per cent of these patients have an infection which could act as a focus.

Alcohol has long been incriminated as a factor in the pathogenesis of NGU. In a group of patients recently studied by this author, 38 per cent were intoxicated within 48 hours of the appearance of the discharge. Recurrences are seen so frequently immediately following straying from our rule of no alcohol that we continue to emphasize

abstinence from alcohol as part of their active treatment. It is well known that alcohol increases the rate of secretion of fluid by the prostate and causes congestion in the gland. Whether this fact or lowered resistance to bacteria, or both, is the cause of this apparent exacerbation of NGU by alcohol is not known.

About 15 per cent of these individuals have a history of prior GC urethritis, and a smaller group apparently develop NGU as a direct sequel to gonococcal urethritis. Penicillin therapy eradicates the gonococcus but leaves a urethral discharge which persists in spite of further massive doses of penicillin. This residual urethritis differs in no way except origin from primary NGU not associated with the gonococcus.

A recent study of young adult males who gave no history of genitourinary tract difficulties revealed one third to have evidence of inflammation of the prostate gland. Urethral discharge is frequently associated with flare-ups of chronic recurrent prostatitis, and one cannot help but speculate as to the relationship between silent prostatitis and the occurrence of NGU. It must be pointed out that we cannot differentiate between NGU and chronic prostatitis with urethral discharge. Interestingly enough, two groups of articles have appeared in our literature—one describing NGU and written primarily by a venerologist and the other describing prostatitis with urethral discharge and written primarily by a urologist—both discussing the same entity.

The notable findings on physical examination are urethral discharge in all, evidenced by rectal examination of prostatic inflammation in approximately 75 per cent and erythema about the urethral meatus in a few.

Positive laboratory findings are usually limited to the urethral exudate, urine and prostatic secretion. The gonococcus should be searched for with smear and culture in every case. A simple 60 second methylene blue stain is of considerable value in establishing the presence of bacteria and outlining their morphological characteristics. Bacteria in an exudate absorb methylene blue far better than the average Gram stain and are therefore better delineated from the surrounding structures. If diplococci are present, their Gram staining characteristics are readily checked on a second slide.

For accurate diagnosis, culture for the gonococcus must be performed. If Gram negative diplococci are cultivated, not only the peroxidase test,

but sugar fermentation should be determined to rule out other organisms of the Neisserian group.

The cytological picture of the urethral exudate varies from a purulent, polymorphonuclear cellular reaction to a mucoid exudate containing many squamous epithelial cells. Examination of wet smears reveals trichomonads in approximately two per cent of the cases, but no factual data support more than a commensal relationship to the urethral flora. Methylene blue and Gram stained smears of the urethral exudate reveal bacteria in all cases, but there is no distinct difference from the flora found in the normal urethra.

Giemsa and Macchiavello's stains are used by many investigators searching for viral and PPLO inclusions. A few English and French investigators report identification of PPLO inclusions and viral inclusions of the psittacosis-trachoma—lymphopathia venereum—inclusion conjunctivitis group in a significant number of cases of NGU. The etiologic significance or validity of these reported findings is not completely established.

Bacterial cultures of the urethra do not reveal a specific etiologic agent. A wide variety of organisms is found, and the organisms do not differ strikingly in type or number cultured from normal urethras. Interesting studies are in progress concerning the possible etiologic role of the pleuropneumonia-like-organisms (PPLO), but no definite causal relationship is established at present. Although PPLO are present in essentially the same number of control subjects as cases of NGU, it is possible that antigenically different species exist which we are unable to recognize using conventional methods.

Attempts to culture viral organisms have thus far failed, and serological studies do not strongly indicate their presence. Improved methods of viral cultivation, including tissue culture media, are in use, and we hope that the controversy concerning "viral" urethritis will soon be settled.

Urinalysis reveals shreds in the first glass; during the early phase, approximately one third have an increased number of WBC's in the second glass specimen.

The prostatic secretion reveals an increased cellular content or clumping of WBC's and decreased lipid content in over 95 per cent of the cases. The flora of the prostate is essentially the same as that of the urethra. Incidentally, no increase in the incidence of epididymitis occurred following gentle diagnostic prostatic massage.

As one can readily appreciate, we are dealing with a mild inflammatory syndrome which involves the lower urinary tract and its accessory secretory acinous glands and not the anterior urethra alone. The etiologic agent is unknown, and the infectious or venereal nature of the syndrome has not been proven.

Treatment is of necessity empiric, but, as a result of trials of various regimens in large series of cases, fairly satisfactory therapy is now available. Rest, abstinence from alcohol and sexual intercourse, and forced hydration are necessary parts of any regimen which offers a reasonable chance of rapid recovery. Calibration of the urethra is necessary and dilatation of any stricture aids materially in controlling the infection. Local heat to the urethra and prostate in the form of sitz baths or diathermy accelerates resolution. Local therapy in the form of irrigations has been used for years and for the most part abandoned until recently when Terramycin and Furacin instillations in the urethra were advocated. It is our impression that necessary concentrations in the proper tissues cannot be obtained in this manner, and irrigating fluids may act as a primary irritant to the delicate urethral mucosa. Stripping of the urethra, promoted by curiosity on the part of the patient, can produce a urethrorrhea and must be prevented. Gentle but adequate prostatic massage establishes better drainage from the inflamed acini of the prostate and is of distinct value in chronic, recurrent cases.

Chemotherapeutic and antibiotic agents have been widely used, and it has now been adequately proven by trial that the "wide-spectrum" antibiotics are our most efficacious form of therapy.

Various sulfonamides, including extremely large doses of sulfadiazine, have been found to be inadequate.

Penicillin or streptomycin, when used alone, are of little assistance in changing the course of the syndrome. However, when combined, they effect disappearance of discharge in a high percentage of cases.

Chloromycetin is effective in approximately two thirds of the cases.

Aureomycin has been reported to be effective in 75 per cent to 90 per cent of all cases and is considered to be one of our most valuable therapeutic agents.

Terramycin has received exhaustive trials, and we believe it to be the drug of choice at present as the result of reported good results in 90-95

per cent of all cases. One gram a day in divided doses for five days is the recommended regimen.

Tetracycline should prove to be quite effective, but it has not received adequate trial to date to warrant preferential use.

Neomycin, Polymixin B, erythromycin and carbomycin have been used in small groups and are not satisfactory.

Urethral discharge recurs in approximately one third of these cases during the first three to six months after therapy is completed. Recurrence is associated with exacerbation of the prostatic inflammation. Prostatic massage is sufficient to stop the discharge in most; however, a second course of antibiotic therapy is occasionally necessary. Late sequelae probably include chronic prostatitis with recurrent symptomatic episodes, calculous prostatitis, prostatitis with median bar formation and occasionally Reiter's syndrome. Stricture of the anterior urethra rarely results from NGU although the course tends to be chronic.

Summary

Nongonococcal urethritis is an inflammatory syndrome of the lower urinary tract and the accessory acinous glands and is not limited to the anterior urethra. The etiologic agent is unknown, and it is not proven to be infectious or venereal. There are indications that the prostatitis is the most important aspect of the clinical syndrome. The "wide-spectrum" antibiotics, particularly oxytetracycline (Terramycin), are the treatment of choice.

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Tuberculosis in Georgia

At present there are about 14,940 cases of tuberculosis on the register at the Georgia Department of Public Health. Nearly 2,300 of these are in state, local and Veterans Administration hospitals. About 600 are in the hospital for the mentally ill and in prisons. There are about 9,000 in their homes classified as active, convalescent, or probably active cases. The remainder on the register are inactive cases requiring medical supervision.

Although the death rate has markedly declined over the past years, the number of cases reported has been almost stationary the past few years, and the case load becomes greater each year.

This increase comes about despite the fact that names are being removed continuously as patients are cured, their disease is arrested, or because of death and other reasons.

Much is being done to control tuberculosis. Physicians at the State Health Department interpreted 228,000 chest x-ray pictures last year and 427 tuberculosis testing clinics were held. Through these activities 523 new cases of the disease were discovered. Much more needs to be done to control tuberculosis and to lessen the growing cost of the disease. Among the factors that tend to perpetuate tuberculosis are those concerned with unknown and unhospitalized cases.

Diagnostic Duodenal Drainage

E. NAPIER BURSON, JR., M. D., and KERRISON JUNIPER, M.D., Atlanta, Ga.

DUODENAL INTUBATION has been done since 1896.¹ Following the publication of the physiological studies on gallbladder function of Meltzer² and the clinical studies of duodenal drainage by Lyon,³ the procedure was widely used in the diagnosis of gallbladder disease. It became known as the Meltzer-Lyon test. Clinicians of the 1920's began to use duodenal intubation as a method of treating patients who had chronic cholecystitis and cholelithiasis. Unfortunately this became known as nonsurgical drainage of the gallbladder. It was realized at that time by some physicians, and later by most, that it was therapeutically unsound. The procedure accomplishes nothing more than emptying the gallbladder, which can be done without use of a duodenal tube by an oral dose of magnesium sulfate or a fatty meal.

As interest waned in its use as a method of treatment, improvements were being made in the techniques of radiographic visualization of the gallbladder. With improved dyes such as Priodax® the need for duodenal drainage as a diagnostic method decreased. By 1940 the method had been discarded by most physicians. This was unfortunate since it remains a useful diagnostic tool when correctly employed.

The purpose of this paper is to define the place of duodenal drainage in our diagnostic armamentarium. The method will be described. Indications for its use and interpretation of the results will be discussed. Our experience is based upon the performance of 250 such drainages over a three year period. A detailed analysis of these cases is to be the subject of a future report.

Procedure of Diagnostic Duodenal Drainage

We have used two types of drainage tubes. Both are of double lumen construction. When

the tube was to be swallowed, a Rehfus tip was used. When it was to be passed through the nose a solid rubber tip or a metal tip no larger than the diameter of the tube itself was employed. The purpose of the double lumen is to allow constant gastric aspiration, thus avoiding contamination of duodenal contents by gastric secretions. If desired, one may prepare his own tube. A section of a Miller-Abbott tube about three feet in length may be used to prepare either the small tip or the Rehfus tip tube. Several small aspiration holes may be cut at appropriate places on each side of the tube. The length of the segment which is to lie within the duodenum should be about six inches. The distance between the duodenal and the gastric aspiration holes should be six inches. If desired, a double lumen Einhorn gastroduodenal tube may be purchased. This has a weighted tip and is appropriately marked by white rings on its outer surface to indicate the approximate location of the tip in the duodenal loop.

No special preparation of the patient was made except omission of breakfast. The tube was always placed under fluoroscopic guidance to expedite the procedure and to be sure of the exact location of the tip. The preferred location is in the third part of the duodenum overlying the spine. If it progresses to the ligament of Treitz, the magnesium sulfate to be instilled as a cholagogue may not readily reach the ampulla of Vater and aspiration may be slower. If the tip is above the ampulla much of the duodenal contents may be missed during aspiration. Use of the fluoroscope, however, in the placement of the tube is not imperative. If the tube is properly marked by external rings its position may be accurately judged. There is amazingly little variation in adult patients. If the marking rings are placed on the tube when properly positioned by fluoroscopy in one patient, the same marks will be correct for most patients. The recovery of clear bile indicates that the tube is in the duodenum. In the patient with complete biliary tract obstruction fluoroscopic placement is almost a necessity.

In the majority of patients the tube may be correctly positioned in a few minutes. When the tube

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hesitates in passing the pylorus, turning the patient on the right side and waiting 10 minutes will usually suffice for passage into the duodenum. When the proper location is obtained, the slack on the tube in the stomach is taken up, and the tube is fixed at the nose or mouth with a piece of tape. The position is then easily maintained without slipping.

With the tube in place, aspiration is started on both gastric and duodenal lumens. A 50 cc. syringe is satisfactory. For convenience, however, we have employed a constant suction apparatus. Duodenal secretions removed at this time are bile-stained and consist of bile, pancreatic juice and secretions of the duodenal glands. This is called A-bile.

About five to 10 cc.'s of A-bile is enough for adequate study. This is usually obtained in about 10 minutes. Forty cc.'s of 33 per cent magnesium sulfate warmed to room temperature is then instilled through the duodenal lumen with the patient lying on his right side. This should be done over a five minute period since rapid injection will produce nausea, retrograde movement of the tube and occasionally a mild collapse.

Magnesium sulfate relaxes the duodenum and allows the gallbladder to empty itself. In the normal patient, about 30 to 50 cc.'s of very dark green or deep brown-yellow bile is collected from the duodenum. This is called B-bile. It usually appears about five minutes after the magnesium sulfate is instilled. After approximately 20 minutes the flow of thick, dark B-bile is replaced by a bile which is thinner and of a lighter color. It is apparently bile from the hepatic ducts which has not entered the gallbladder. This third and last specimen is called C-bile.

A sample of each specimen is placed in a centrifuge tube and is spun at 1800 rpm for 10 minutes. All but two or three cc.'s is decanted but saved. The residue is carefully aspirated from the bottom of the tube and mounted on a slide. A cover-slip, preferably a 15 x 30 mm. size is used. The specimen is then ready for microscopic study. If Papanicolaou studies are to be done, each of the three duodenal samples is collected in iced test tubes and Papanicolaou smears are prepared according to the technique of Lemon.⁴

Interpretation of the Procedure

The information obtained is confined almost entirely to the microscopic study of the fresh material or of the Papanicolaou slides. The gross appearance of the bile is seldom of value, although

occasionally macroscopic stones may be recovered. While it is true that the prompt appearance of dark, thick B-bile indicates adequate emptying of the gallbladder, this is of little practical value since this may occur in either the normal or diseased biliary system. By the same token, the failure of the bile to appear does not necessarily indicate a poorly functioning gallbladder or a diseased gallbladder. It has no more significance than the failure of the gallbladder to empty during the radiographic procedure. In the bile recovered from a normal biliary system there is little to be seen in the microscopic preparation. Occasional epithelial cells, a few white cells or a few macrophages may be observed. Red cells are sometimes seen. They are usually due to the trauma of the tube or of the aspiration, but they may also occur in the presence of ulcer or tumor.

Abnormal constituents of bile which are of diagnostic significance are cholesterol crystals, calcium bilirubinate pigment, malignant cells and parasites. It is likely that there are other crystalline structures and cellular elements which are of diagnostic importance also, but these have not been studied sufficiently to determine their significance.

The typical cholesterol crystals are readily recognized. They may be described as resembling bits of shattered window-pane. A typical crystal has a distinct notch in one of its corners. The margins of the crystals are otherwise straight. These crystals are colorless. They vary from 10 micra to macroscopic in size. Often they are in clumps, suggesting a bit of broken cholesterol stone. Figure 1 illustrates the appearance of these crystals in the bile recovered from a patient with cholelithiasis.

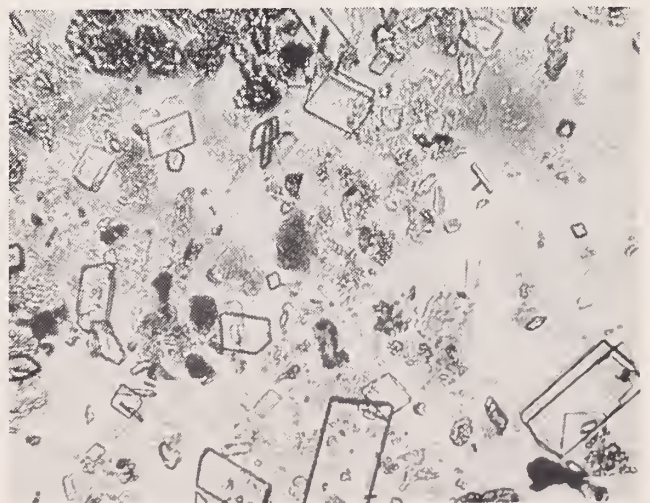


Figure 1. Cholesterol Crystals

Calcium bilirubinate pigment is often referred to as calcium bilirubinate crystals. It is amorphous or granular in structure. It usually appears in clumps. It is readily identified by its color, which is a brilliant orange or a golden yellow. Figure 2 illustrates the appearance of this pigment recovered from abnormal bile.

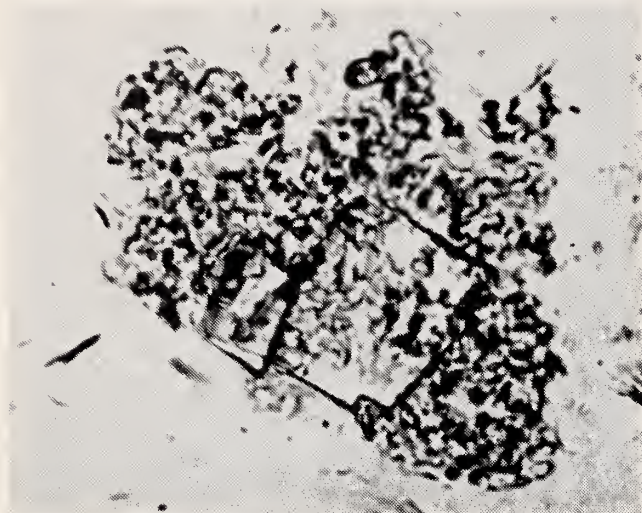


Figure II. Calcium Bilirubinate Pigment. This surrounds two large cholesterol crystals.

Malignant cells are difficult to identify except by one who has had special training in the Papanicolaou technique. In this study we were fortunate to have the help of the pathology department of the Atlanta Veterans Administration Hospital. Two members of this department who had studied the cytologic method under Dr. Papanicolaou interpreted our cellular preparations.

Fig. 3 illustrates grade V cells recovered from a duodenal drainage.

Clinical Applications

Our experience with diagnostic duodenal drainage has led to its use in the following situations:

1. *Suspected tumor of the pancreas, duodenum, liver, gallbladder or biliary tract:* Recovery of malignant cells from the duodenal aspirate has the same significance as such cells recovered from other malignant areas. The exact site of course cannot be stated. The carcinoma may be in the liver, ductal system, gallbladder, duodenum or pancreas. It is not likely to be in the stomach since malignant cells there are rapidly digested, and a special technique is required to demonstrate them. We have followed Papanicolaou's classification of malignancy. Cell types I and II are negative. III is doubtful. IV, V and VI are positive for malignancy. In our series there have been two positives, both confirmed by surgery. No false

positives have occurred. There is one patient classified as Class III whose exact diagnosis remains undetermined. To our knowledge no false negatives have appeared, although longer follow-up on many of these patients is necessary to confirm this.

2. *Jaundice of undetermined etiology:* Papanicolaou studies should always be a part of the procedure when it is applied to the differential diagnosis of jaundice. A positive smear is almost certain to explain the jaundice. The presence of cholesterol or calcium bilirubinate pigment or both is suggestive that the jaundice is due to cholelithiasis. It is entirely possible of course that incidental cholelithiasis may be present when hepatitis or malignancy accounts for the jaundice. In such instances a diagnostic error may occur. It can only be said that this is a laboratory test and is subject to error under certain conditions. Another source of error in the jaundiced patient is the appearance of cholesterol and calcium bilirubinate crystals when the patient has been deeply jaundiced for two weeks or longer due to some cause other than cholelithiasis. Such occurrences are unusual.

3. *Cases of suspected gallbladder disease with a normal or questionable cholecystogram:* It is with this group of patients that duodenal drainage has its greatest usefulness. It is apparent that a

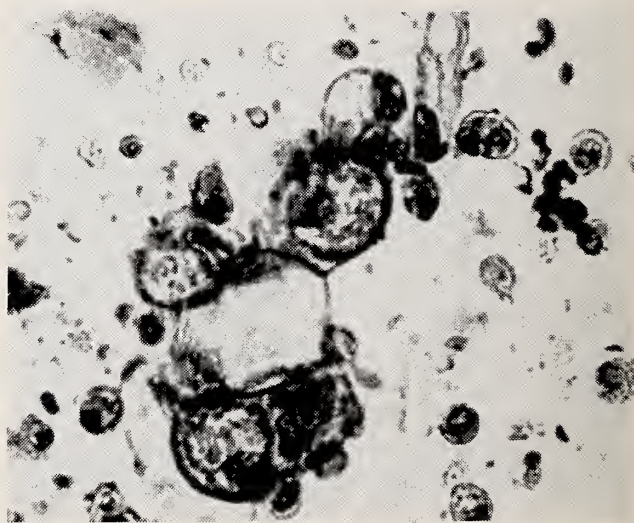


Figure III. Class V Papanicolaou smear from carcinoma of the pancreas.

normal cholecystogram may sometimes occur when the gallbladder is diseased. This is seen under circumstances of poor radiographic technique, in the obese patient, when the gallbladder is obscured by overlying rib shadows or calcified costal cartilages, when the dye is vomited or produces

severe diarrhea, when tiny stones are obscured by the concentration of dye in the gallbladder, and when cholesterosis of the gallbladder is present. Since patients with radiologically normal gallbladders seldom have their gallbladders explored, the frequency of a falsely negative cholecystogram is unknown.

In six cases we have recommended surgery when the cholecystogram was reported to be normal, while the duodenal drainage was positive and the patient had an adequate clinical history for cholelithiasis. The presence of cholecystitis or cholelithiasis has been confirmed in every case. There are numerous such cases reported in literature.⁵

When the patient is not jaundiced, the presence of typical calcium bilirubinate pigment in three or more microscopic fields may be considered diagnostic of chronic cholecystitis. The same is probably true for cholesterol, but, because of the appearance of an occasional typical cholesterol crystal in bile from normal gallbladders (autopsy specimens), a positive report is made only when typical cholesterol crystals are present in 10 or more microscopic fields. It is seldom necessary to make a decision based on only a few crystals. As a rule they are absent entirely or present in most microscopic fields.

4. *In the non-visualized gallbladder when opaque stones and typical biliary pain are not present:* The same criteria for a positive report apply here as for suspected cases (indication number three) of biliary tract disease with a normal X-ray.

5. *If the question of biliary duct stone arises after cholecystectomy:* This has not been a very helpful application of duodenal drainage. Usually the situation may be resolved by some other method. If the cholecystectomy were performed for cholelithiasis, particularly if the patient were jaundiced, calcium bilirubinate and cholesterol crystals may still be within the ductal system for a few weeks although a stone may not necessarily be responsible for the post-cholecystectomy complications. The presence of abnormal crystals on duodenal drainage shortly after cholecystectomy in this situation is suggestive of biliary stone but not diagnostic.

6. *The diagnosis of upper gastrointestinal parasitism:* With one possible exception, parasites

have not been responsible for gastrointestinal symptoms in our series. It is seldom that the procedure would be performed for this purpose alone.

Summary

The technique of diagnostic duodenal drainage may be easily learned. The necessary equipment is simple and inexpensive. It may be performed rapidly with little discomfort to most patients. Its chief value lies in the detection of cholelithiasis or chronic cholecystitis when the cholecystogram is negative or doubtful. It should be a routine procedure if cholelithiasis is suspected clinically and not confirmed radiologically.

The use of this method *in the properly selected case* will increase the accuracy of diagnosis of biliary tract disease and is worth the time required.

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Diabetes Week—November 14-20, 1954

Impairments Affecting Employment

CHRISTOPHER J. McLOUGHLIN, M.D., Atlanta, Ga.

HISTORY HAS BROUGHT down to us from all civilizations the multiple problems of the handicapped. The value of slaves in ancient Egypt and Rome is known to have been diminished considerably because of impairments received during a lifetime. Until comparatively modern times, and, in fact even in modern times, very little attempt has been made to take advantage of the abilities of the impaired individual rather than to cast him aside because of his infirmities. Only recently therefore have we come to realize that sound economic and social principles afford us the opportunity of making use of the abilities of these impaired ones, and thus, by permitting them to become an integral part of the industrial scheme, a severe financial burden on society may be alleviated.

In 1933, in the midst of a tragic depression, many men regardless of physical or mental ability and willingness to work were unable to find employment of any kind. Ten years later, with the world in chaos, every so-called physically fit male was called into military service. Only then did the nation begin to realize the tremendous importance and real value of the man with a handicap. At long last a job was found for the man rather than a man for the job. Surprisingly few could not be placed in some position in which their talents could be utilized. Many reports about this great army of handicapped workers, for whom no position could be found, reveal that the number of those rejected because of incapacity ran only between one and two per cent.

An occupation seldom requires only one quality of the worker. Every occupation carries with it demands for work in a particular environment. It needs a certain aptitude and intelligence. The person in that occupation must develop through experience a particular skill and must have, not only the physical qualifications, but the interest and nervous stability required to do the job prop-

erly. If a man has the ability to meet the needs of a particular job, he should not be considered as having an impairment for that job regardless of his strength or weakness, his stolidity or nervousness, his great technical skill or clumsiness. Quite recently, the Veterans Administration estimated that by the time a man is 60 he must have at least a ten per cent disability of some sort. If we speak therefore of disability as being any deficiency whatsoever, then there is scarcely one among us who can be called whole. Very few men at the age of 30, except possibly professional athletes, can play football, run, throw a ball or swim as well as they could 10 years previously. Yet, what average man of 40 would consider himself impaired simply because he is slowing down. Fortunately, however, few jobs are so arduous as to demand physical perfection.

There are three questions which must be answered in considering a worker for a position:

1. Can that particular man do that particular job?
2. Will that particular job increase that man's impairment?
3. Will the impairment endanger the employee or other employees?

Most handicapped people may be employed with some restrictions upon activity. For example, certain individuals must wear a truss, safety spectacles or special shoes. Some cannot do any back bending, climb ladders or stairs or do any heavy lifting. Some cannot work around toxic materials. Some may not work in cold quarters: others cannot stand a hot environment. Some cannot work if the atmosphere is too dry or too wet, some cannot work indoors and some, not outdoors or around dust. Perhaps they cannot work alone, or sometimes they work better alone. Some cannot perform a task requiring acute hearing, acute vision or avoidance of nervous tension, etc.

Let us consider some of the more common defects encountered in those applying for work and in whom these conditions could be considered as impairments affecting employment.

From the Department of Medicine, Emory University.
Read before the Occupational Health and Rehabilitation Conference, Academy of Medicine, Atlanta, Georgia, October 9, 1953.

Age: in 1950, there were 12,000,000 persons in this country 65 years of age or older. The age problem poses perhaps the greatest obstacle to the hiring of a man for a job.

Allergies: The total number of people so afflicted can scarcely be estimated. Probably, from time to time, half the population of this country suffers, at least to a mild degree, from some allergic condition.

Amputees: The number has been variously estimated from 500,000 to 2,000,000. The most generally accepted figure is 900,000, of whom about 400,000 have suffered a major amputation. Approximately 20,500 men in military service during World War II had major amputations, and 65,000 war workers had major amputations as a result of accidents.

Arthritis: Ten million people in the United States suffer from rheumatism in varying degrees. Of these, at least 1,000,000 are considered physically handicapped to a great extent by this condition.

Cardiovascular diseases: Approximately 9,000,000 suffer from diseases of the heart and arteries. Of all men rejected by Selective Service during the war, 6.6 per cent were disqualified because of cardiovascular difficulties. This represents a particularly serious problem, for in one series of over 15,000 men and women considered normal and over 40 years of age in all walks of life, it was found that 41 per cent of men and 51 per cent of women had blood pressures over 150 systolic and/or 90 diastolic. Thus, almost one of two workers over the age of 40 could be considered physically handicapped by generally accepted standards.

Cerebral Palsy: The total number varies from 175,000 to 336,000 so afflicted.

Dermatologic conditions: The skin conditions with which workers are afflicted are countless and vary from a mild dermatitis to severe exfoliating conditions which could easily lead to death.

Diabetes Mellitus: Over a million known diabetics and more than a million undiscovered diabetics make up the population of this country. With the increased longevity and the greater percentage of older people, this number will probably be close to three million known and unknown diabetics.

Ears, nose and throat: The estimates on those handicapped because of impaired hearing varies from seven to 14 million; 800,000 wear hearing aids; twice this number need them. The Veterans Administration estimates that within 20 years the

number of World War II veterans needing aural rehabilitation may be expected to increase to 200,000. Approximately 10 per cent of all children have some form of speech difficulty, and in five per cent the disorders may be sufficient to demand special assistance.

Epilepsy: Estimates vary from 500,000 to 1,500,000. Approximately 50,000 of these persons are institutionalized. However, some studies report that epileptics were found to show no unusual incidence of general organic disease. Nine out of 10 had average muscular strength and control, and it was concluded that at least 75 to 85 per cent of epileptics could be fitted for employment under normal conditions. Naturally, certain types of work should be ruled out from the start. No one would suggest that an epileptic obtain a job as a steeple jack, yet there is the well known story of an epileptic who was a steeple jack. He had many of his convulsive seizures while aloft, where he was held securely in his safety harness. One day while on the street he had a convulsive seizure and was run down by an automobile.

Eye: There are approximately 230,000 blind in the United States.

Hernias: By far the greatest number of impairments (34 per cent) found in one survey was due to hernia. Fortunately, most of these are amenable to treatment by surgery or control by a truss.

Malformations: In this category it is very surprising to see the tremendous amount of compensatory agility that patients with malformations can develop. We have in our hospital at this moment a woman of 42 in whom the thumb and phalanges of the left hand are each less than an inch long. Nevertheless, she finds this does not handicap her in knitting, playing cards, golfing, sewing, etc.

Neurologic defects: Among nearly 5,000,000 registrants for Selective Service between the ages of 18 and 37 years, 4.9 per cent had neurologic defects.

Orthopedic impairmentss: About 2,600,000 are estimated to have orthopedic impairments, of whom 341,000 are afflicted with incapacitating impairments.

Poliomyelitis: Six out of every thousand in one report show evidence of having had some degree of infantile paralysis.

Pregnancy: Generally is not too incapacitating, as it is usually self-limiting in duration but prone to recurrences.

Tuberculosis: There are approximately 300,000 clinically significant active cases of tuberculosis. The number of patients in the nation requiring rehabilitation is approximately 150,000.

Veneral disease: This antibiotic age has almost completely dismissed this problem.

Many of you will ask, since approximately 98 per cent of handicapped individuals can have a job fitted to their capabilities, why industry does not make more use of the partially disabled. Does the fault lie with the physician and the pre-employment examinations, is it with the employers or with the unions? In certain instances any of these may be at fault. Some employers require almost perfect physical fitness in order that a man may be moved from one job to another without having to stop to evaluate his physical shortcomings. Frequently the industrial physician may feel obligated to protect the employer from persons who might possibly have an increased rate of disability from illness or accident. Industry, however, is now becoming increasingly aware of its responsibility. When approached in the proper spirit it is quite willing to assume this responsibility.

Labor unions at one time were very much against periodic and pre-employment examinations on the basis that the findings were misused, to the disadvantage of the employee. The claim was in many cases justified. Unions have come to realize that periodic examinations of workers are wise, and in many cases essential, for the welfare of all. For example, any one known to have had a tuberculous lesion could be a possible danger to other employees, and they should have periodic check-ups. Other conditions require periodic observations—among which are hypertension, cardiac disease, diabetes, tests of vision, hearing, etc.

The highest rate of rejection of applicants usually is found in states in which compensation is allowed for alleged aggravation of pre-existing disabilities or non-disabling defects. The alleged aggravations are not infrequently malingering. In

some states the lack of funds to provide for second injuries for workers with minor defects provides a stumbling block to the employment of impaired workers. A man with only one good eye would usually be rejected because if he lost the good eye, the employer would then be liable for compensation for total blindness. All but six states now have provided funds for second injuries, and employers no longer need fear a worker's becoming totally disabled.

Therefore, with the unions cooperating and industry for the most part willing to assume its responsibility, we must depend upon the physician to play his part in the plan. The industrial physician cannot do his work behind a desk; he should step out and appraise the specific needs of specific jobs. He must know the dangers and responsibilities of particular positions. This first-hand appraisal of a job, plus good clinical judgment, plus teamwork between the physician and the supervisor, will insure the proper placement of many. There must be a balance, not only of the requirements of a job, but also of the physical capabilities of the employee. This balance will mean that the physician has taken into consideration the abilities of the worker, rather than his disabilities.

The advantages that will accrue through proper placement of every applicant for a position will be many. From the standpoint of industry, it has been reported that in the majority of instances the handicapped worker is at least as good, if not superior, to the able-bodied man. This is probably due to the fact that the employee with an impairment develops pride in the performance of his work. He becomes enthusiastic on finding that he is able to hold his own in competition. His self-respect is restored when he finds that he is not a burden on his family or the community, and he soon learns to keep his head high as he loses the sense of insecurity which naturally follows when a person finds himself unwanted.

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AMEF Kicks Off Campaign

American Medical Education Foundation state chairmen will kick off the 1955 fund-raising campaign with a meeting Sunday, Jan. 23 at the Sheraton Hotel, Chicago. This fourth annual meeting will launch officially the medical profession's concerted efforts to raise voluntary funds for the

nation's medical schools.

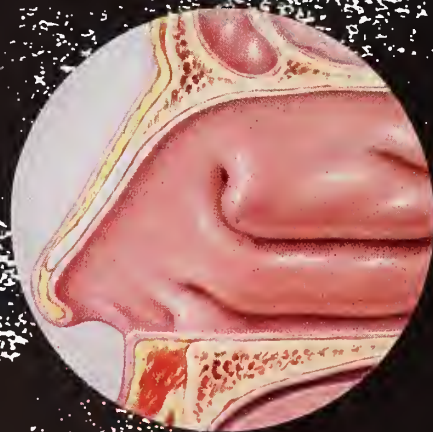
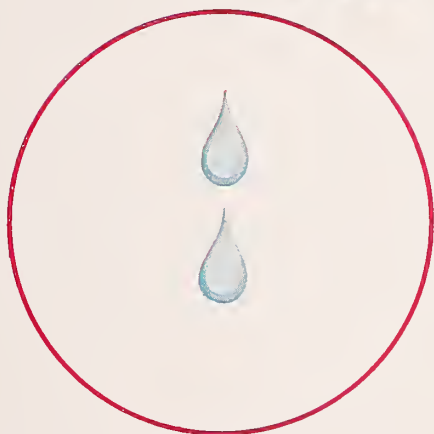
Primary purposes of the one-day session is to exchange ideas on local promotions. Representatives from every state as well as regional auxiliary chairmen will be on hand for the meeting.

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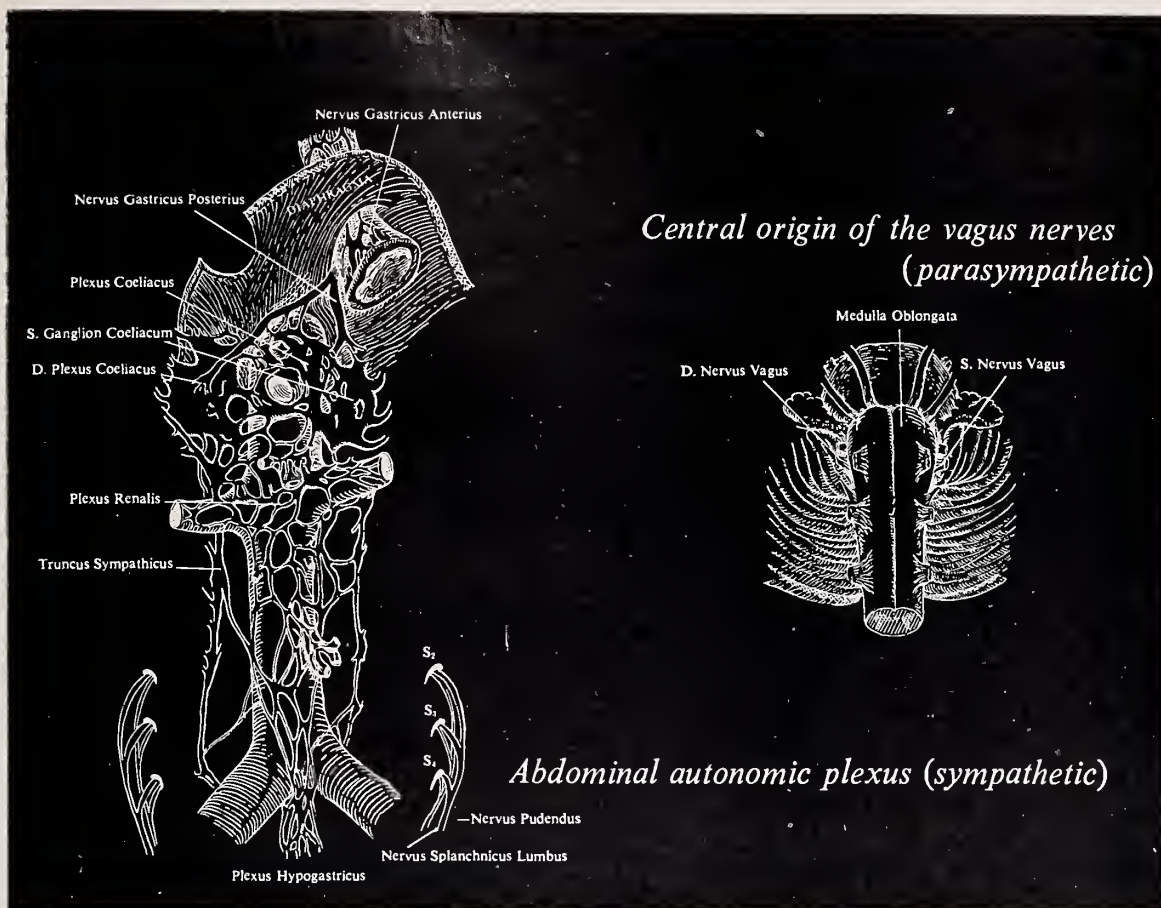
**BILATERAL
ARTERIOSCLEROTIC
ULCERATION** in patient age 65.
At start of Priscoline therapy;
ulcer, right leg, $1\frac{3}{4}'' \times 1\frac{1}{4}''$;
ulcer, left leg, $\frac{1}{2}'' \times \frac{1}{2}''$.
With oral Priscoline, 25 mg. four
times daily for one week
and 25 mg. every three hours
thereafter, there was marked
improvement in 2 weeks
and healing within 6 weeks.
No other medication given.



**HYPERTENSIVE ISCHEMIC
ULCER** of right leg in patient
age 65. Ulceration refractory to
treatment for 9 months, with
patient complaining of severe pain.
Treated with oral Priscoline,
50 mg. four times daily for four
days and 50 mg. every four
hours thereafter. Healing began
with onset of Priscoline therapy
and was complete in 10 weeks.

PHOTOGRAPHS AND CLINICAL DATA
BY COURTESY OF R. I. LOWENBERG, M.D.,
CONSULTANT IN VASCULAR SURGERY,
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C I B A



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1. Zupko, A. G.: Pharmacology and the General Practitioner, GP 7:55 (March) 1953.

2. McHardy, G. G., and Others: Clinical Evaluation of Methantheline (Banthine) Bromide in Gastroenterology, J.A.M.A. 147:1620 (Dec. 22) 1951.

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abstracts by georgia authors

Williams, G. A., Moseley, T. H., and Whicker, C. F., 710 Peachtree St., N.E., Atlanta, Ga. "Cesarean Section in an Open Staff General Hospital," *Am. J. Obst. & Gynec.* 68:606-617 (Aug.) 1954.

Abdominal delivery has been utilized more extensively in the past two decades and has undoubtedly contributed to the marked reduction in maternal mortality. The use of cesarean section varies widely from 0.65 per cent in a southern charity hospital to virtually 10 per cent in some of the west coast hospitals. The Crawford W. Long Memorial Hospital is an open staff general hospital in which 26,954 deliveries were conducted in the five year period (1948-1952). During that time, 563 cesarean sections were performed, an incidence of 2.09 per cent. This, of course, seems low by some standards, but was about the average of the Atlanta private hospitals during that time. There was only one maternal death rather ironically due to gastroenterocolitis as a result of aureomycin sensitivity. Conduction block methods were preferred for anesthesia, being used in 70 per cent of the cases. The indications for cesarean section were not unusual, previous section, cephalopelvic disproportion, and hemorrhage leading the list. The fetal salvage was satisfactory, the uncorrected mortality for term babies being 2.4 per cent and that of pre-matures 18.2 per cent. Maternal morbidity as measured by usual standards was so low that the authors conclude that all significant complications must be grouped with febrile cases to give a satisfactory estimate of morbidity. It is thought that this study at Crawford W. Long Memorial Hospital is an index of what the average American white woman can expect from cesarean delivery because it is an open staff general hospital, not dominated by any single individual and general practitioners deliver almost half of the patients. The incidence of cesarean section in Atlanta hospitals is so low, as compared to the national average, a city wide study would be highly desirable.

Greenblatt, Robert B., Medical College of Georgia, Augusta, Ga. "Vagaries in the Symptomatology of Cushing's Syndrome," *Clin. Endocrin. & Metabolism* 14:961-968 (Aug.) 1954.

The corticometabolic syndrome, or Cushing's syndrome, occurs as a result of the overproduction of corticoid hormone acting on carbohydrate, fat, and protein metabolism. Most patients with this disturbance show changes in the sexual sphere, but is thought that these features are the expression of a concomitant androgenic overactivity. This overactivity is usually such as to pseudomasculinize the patient, i.e., the female is usually amenorrheic and hirsute, but without voice changes or enlargement of the clitoris. Frequently the male is, in a measure, demasculinized. At times the female patient with Cushing's syndrome is definitely virilized, and androgenic activity as measured by urinary 17-ketosteroid titers is considerably increased.

Regardless of whether the pathogenesis is primarily (a) a basophilic adenoma of the pituitary, (b) a lesion of the hypothalamus, or (c) an adrenal tumor or adrenal hyperplasia, hyperfunction of the adrenal cortex is necessary for the production of the signs and symptoms of Cushing's syndrome (except in the rare case of ovarian tumor of adrenal rest origin.)

The wide spectrum in the signs and symptoms found in Cushing's syndrome is stressed. Two patients with proved Cushing's syndrome are presented whose signs and symptoms placed them at either end of this spectrum. One patient with so-called "pure" Cushing's syndrome was very weak, markedly osteoporotic, and free from hirsutism, but the other patient, a case of mixed adrenogenital-Cushing's syndrome was strong, virilized, and free from osteoporosis.

Diagnostic procedures and the management of these two cases are discussed.

Johnson, C. A.; Brawner, Darnell; Skiles, W. Vernon; and McCain, J. R., 56 Fifth St., N. E., Atlanta, Ga. "The Nonoperative Treatment of Inevitable and Incomplete Abortions," *Am.*

J. Obst. & Gynec. 68:576-588 (Aug.) 1954.

This paper deals with 454 patients admitted to the hospital with either inevitable or incomplete abortions. The criteria for these conditions being stated in the paper, 91.9 per cent of these patients completed the abortion by the nonoperative method. The nonoperative treatment had to be abandoned because of excessive or prolonged bleeding. Resume of the plan of treatment is given and the results are discussed in reference to the time of completion of the abortion, infection, and hemorrhage. Tables on the distribution of transfusions and the length of hospitalization are given. Nine maternal deaths in this series are summarized in a table.

Shirley, W. C.; Torpin, Richard; Mullins, D. Frank Jr., Medical College of Georgia, Augusta, Ga. "Embryologic Tumors of the Uterine Tube", *Obst. & Gynec.* 4:194-196 (Aug.) 1954.

Embryologic tumors of the fallopian tube are extremely rare. A careful survey of the literature reveals only 25 recorded cases, only five having been reported in English.

CASE REPORT

A 33-year old gravida I, para I, Negro woman was admitted to the University Hospital with a diagnosis of pelvic inflammatory disease. At operation there was a tumor about the size of an orange in the middle third of the left uterine tube. Both ovaries were carefully examined and showed no evidence of pathology. A left salpingectomy (which included the tumor mass) and appendectomy were done.

The pathology report was infected cystic teratoma of the left fallopian tube.

Lynch and Maxwell have summarized several theories as to the origin of this type of tumor. The majority believe they develop from aberrant ovarian tissue which has been included in the folds of the broad ligament. Others hold that they arise from an impregnated egg, from which one of the original cell elements has been extruded, and exist as a fetal inclusion as a fetus within a fetus (blastomere). Others see the growth as an expression of misplaced germ cells, which develop parthenogenetically. A few consider that they represent defective twin development.

Campbell, John D., Doctors Bldg., Atlanta, Ga. "Electroconvulsive Therapy and Depressions". *Dis. Nerv. System* 15:241-249 (Aug.) 1954.

Since the introduction of electroconvulsive therapy in 1938 this form of treatment has grown rapidly and widely. Prejudices and misunderstandings concerning electroconvulsive therapy (ECT) are explained. Chief indication for this treatment is melancholia or mental depression, although many of these depressed patients may also suffer with fatigability, insomnia, crying spells, menstrual disturbances, anorexia, loss of weight, headaches or indigestion. Dipsomaniacs, those who drink because of periodic depressions, are helped by ECT. ECT is only an adjunct; rest, correction of environmental complications and psychotherapy must follow this treatment. Conditions once thought to be contraindications to ECT, such as hypertension, arteriosclerosis, cardiovascular disease, pregnancy, tuberculosis, old age and bony deformities are no longer so considered. Transient impairment in memory is practically always a complication of ECT, but there is no permanent brain damage. Compressed fractures of dorsal vertebral bodies occur occasionally but are not disabling. As in all medical problems the dangers of the illness, such as malnutrition, prolonged psychosis and suicide must be weighed against the possible complication of the treatment, such as fractures. ECT does not produce its results by fear or by blocking out the memory; a substantial physiological change occurs. A scientific discussion of how ECT produces its results is given, along with the suggestion that ECT may lead to fruitful research projects concerning the cause of mental illness. It is concluded that ECT has rehabilitated a great many people of poor or moderate means who couldn't afford long and expensive psychiatric treatment and who did not want to go to state hospitals. ECT is the most important advance in psychiatry in 50 years.

doctor placement page



NOTE: The Medical Association of Georgia assumes no responsibility for information herewith printed—it is for information only. Anyone interested is advised to make such investigations for verification as he deems necessary.

AVAILABLE PHYSICIANS

Berry, Reginald V., M.D., US Naval Hospital, Pensacola, Florida, age 47, married, Protestant, graduate Yale Medical School, 1932, residency Duke University, North Carolina; U. S. Naval Medical Center, Maryland, interested in psychiatry and neurology in Georgia (clinic, assistant associate or institutional), available July-August 1954.

Fitz, Thomas E., M.D., 1053 Oakland Avenue, Rock Hill, South Carolina, age 32, married, 3 children, Presbyterian, graduate Duke University School of Medicine, 1949, specialty—internal medicine and cardiology presently in practice, wishes to relocate due to economic status, desires group or associate practice, available within two or three weeks after location secured.

MacKavanagh, James L., M.D., 160 Marion Avenue, Marrick, L. I., New York, age 44, married, Roman Catholic, graduate Georgetown University Medical School, 1934, presently in general practice, wishes to relocate, priority 3, interested in general practice in Georgia, size of community not too important, available within two or three months after location is selected.

Pattison, John D., M.D., FASRON 104 Det. 1, FPO, New York, N. Y., age 34, married, Protestant, graduate University of Pittsburgh, 1944, residency VA Hospital, service completed October 5, 1954, specialty internal medicine, clinic or group practice in Georgia, available one or two months after discharge.

McCorkle, Robert G., Jr., M.D., 350 South Fuller 4J, Los Angeles, Calif. Age 30; married; Catholic; graduate Baylor University School of Medicine, 1946; priority 4; specialty—Thoracic Surgery. Interested in association with another doctor. Available August 1, 1954.

Stark, C. V., M.D., Box 109, Arcadia, Fla., wants practice in Georgia during spring of the year only, as he spends winters in Florida, born November 25, 1878, widower, graduate Oploma Medical University, Tenn., 1900, specialty—general medicine, population 1,000 or more.

Shanahan, John Rush, M.D., 10310 Greenfield Street, Kensington, Maryland. Age 39. Married; Roman Catholic. Graduate Georgetown University, 1948. Residency U. S. Naval Hospital, Bethesda, Maryland. Priority 5. Specialty—Internal Medicine. Desires community in Georgia of 20,000 to 30,000. Available June, 1955.

McCorvey, Norborn B., M. D., 543 Garfield Street San Francisco, California; age 34; married; Presbyterian; graduate Tulane University School of Medicine, 1944 residency, Jefferson-Hillman Hospital; 3½ years residency in Urology; Priority 4; available immediately.

McCoy, John M., (Capt. 059752), 121st Evacuation Hospital, APO 971, c/o Postmaster, San Francisco, California; age 31 married, 2 children; Presbyterian; graduate Duke University, 1947; residency - George Washington University Hospital, VA Hos-

pital; eligible to take Part II, American Board of Internal Medicine; available March 1, 1955.

Upchurch, Kent P., 215 Pine Valley Road, Winston-Salem, N. C.; age 30; married; Protestant; graduate Bowman Gray School of Medicine, 1946; Board qualified in Ob and Gyn; interested in group practice or woman's clinic as an assistant or associate; available September 1, 1954.

Snelling, John M., Jr., M. D., 1506 Waverly Avenue; Charlotte, N. C. Born in Augusta, Georgia; graduated from Medical College of Georgia, 1943; in June 1953 completed a four year residency in general surgery at Youngstown Hospital, Ohio; prefer solo practice, but would consider an association; Board eligible; if necessary could do some general practice to get started; now available.

Sullivan, Francis Simon, 4368 Carnegie Street, Wayne, Michigan; age 29; married Presbyterian; graduate University of Virginia, 1949; residency - Wayne County General Hospital; 3 years residency in internal medicine; priority 4F; specialty internal medicine; available October 1954.

Berry, Bradley D., M.D., Whitfield, Mississippi; graduate Jefferson Medical College, Philadelphia, Pennsylvania; completed internship; interested in general practice in Georgia.

Crupie, Joseph E., M.D., 347 Plant Street, Apt. 4-F, Tampa, Florida; age 30; married; graduate University of Tennessee School of Medicine; 1953; Priority IV; interested in general practice in Georgia; available 1st week in February 1955.

Frerichs, Cletus T., M.D., 1221 Sixth Avenue, S.E., Rochester, Minnesota; age 30; married, two children; Lutheran; graduate University of Nebraska School of Medicine, 1947; 3 year fellowship in internal medicine at the Mayo Foundation; specialty—internal medicine; prefers community of 15,000 up; available January 1, 1955.

Stewart, Lena M., M.D., 250 N. Ottawa Street, Joliet, Illinois; age 65; single, Methodist; graduate Chicago College of Medicine and Surgery; 1917; residency—Deaconess Hospital; presently in practice, desires a milder climate; interested in general practice for girls school or student health; available November 1, 1954.

Watson, Alfred Lawrence, M.D., 1415 Titus Road, Memphis 11, Tennessee; age 29; married; Methodist; graduate Vanderbilt University School of Medicine, 1949; residency—2 years at Grady Hospital, Atlanta in internal medicine and at Kennedy Veterans Hospital, Tennessee; Priority IV; specialty internal medicine; prefers clinic, assistant or associate; available July 1, 1955.

Brooking, Donald G. W., M. D., 228 Finley Drive, Decatur, Alabama. Age 33; married; Protestant; graduate University of Minnesota, 1948; residency Brooke Army Hospital and Cornell University Medical College; passed examinations for certification by American Board

of Dermatology and Syphilology; interested in Dermatology in a clinic, as assistant or associate or industrial; available immediately.

Calisch, Louis H., M.D., U. S. Naval Hospital, Charleston, S. C. Age 31; married; Jewish; graduate University of Virginia Medical School, 1947; residency Johnston-Willis Hospital; finishing 27 months of active duty; specialty internal medicine; available January 1, 1955.

Collins, Douglas, M.D., 172 Riverside Park, Iowa City, Iowa. Age 33; married; Methodist; graduate University of Alabama School of Medicine, 1951; residency State University of Iowa Hospital; specialty Ob-Gyn; available July 1, 1955.

Gianoulis, James T., M.D., 611 West Grace Street, Richmond 20, Virginia. Age 38; married; graduate Medical College of Virginia, 1941; interested in general surgery and gynecology; Priority IV; six year surgical residency at Medical College of Virginia Hospital; looking for a permanent location with a future.

Gwinn, John L., M.D., 1309 Third Avenue, S.W., Rochester, Minnesota. Age 32. Married; Protestant; graduate University of Louisville, 1946; residency Mayo Clinic; finishing a fellowship in pediatrics; priority IV; specialty pediatrics; prefers practice in Georgia; available January 1955.

Hunter, I. H., M.D., 204 East Hill Avenue, Valdosta, Georgia; age 73; married; Missionary Baptist; graduate Grant University, 1903; interested in general practice; specialty pediatrics; prefers community of 1,000; will accept good position with clinic; available immediately; been in active practice for 50 years.

McConnell, Ben H., M.D., Box 664, Beltsville, Maryland. Seeking position as a student health physician. Age 36; married; Episcopal; graduate Georgetown University, 1950; interested in general practice as student health physician with any school, college or university; available at once.

McGarry, Paul A., M.D., Charity Hospital, New Orleans, Louisiana. Age 26. single; Roman Catholic; graduate Temple Medical School, Philadelphia, Pennsylvania 1954; presently intern; 2A Priority 3; interested in general practice in a rural area; available August 1955.

Outlaw, Robert J., M.D., Saluda, S. C. Age 30; married; Methodist; graduate S. C. Medical College, 1951; presently in practice, wishes to relocate; desires partnership, also area with hospital facilities; interested in general practice in Georgia; available immediately.

Seruggs, W. H., M.D., Bryson City, N. C. Age 65; limited general practice; 1 year in TB work, 3 years in general surgery; licensed in Georgia; married; Baptist; graduate University of Maryland, 1913; prefers small town with hospital. Available immediately.

Vildbill, James Wm., M.D., 919 Ford Street, Corona, California. Age 29; married; Presbyterian; graduate Tulane, 1948; residency Charity Hospital; presently in USN; specialty urology; prefers practice in Georgia; available no later than November 1, 1954.

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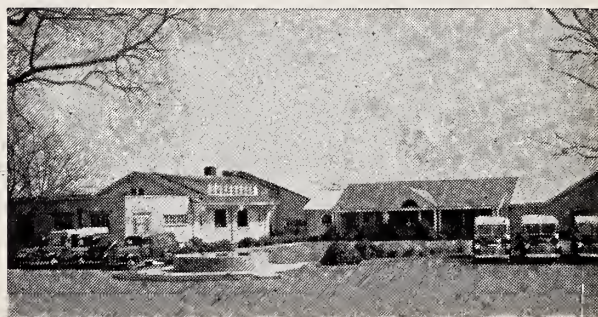
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AVAILABLE LOCATIONS

Meigs, Georgia - Thomas County - one doctor's clinic available, with ample space for a two doctor set-up; one aged doctor; hospital facilities nearby; good schools; paved highways; contact: Mr. O. H. Lewis, Meigs Clinic, Inc., Meigs, Georgia.

Pearson, Georgia - Atkinson County - will furnish house and equip clinic; new Hill-Burton Hospital at Douglas guarantees staff privileges to GP; office will be rent free for six months; contact Mr. Barney Kraft, Pearson, Georgia.

Villa Rica, Georgia (Carroll County) - New 24 bed HB hospital to be built soon. Now have seven bed hospital. Office available for lease, reasonable. Housing available at reasonable cost. 12 grade accredited school. (Pop. 3,200). Contact: Mr. Edgar P. Candler, Villa Rica, Georgia.

Marietta, Georgia - Cobb County - Interested in Negro physician to replace present physician who is going into armed forces. Contact Mr. Millard L. Wear, Administrator; City of Marietta Hospital Authority; Kennestone Hospital, Marietta, Georgia.

Roberta, Georgia - Crawford County - No physician in area, county maintains a large home with most reasonable rental available for resident doctor. Plans for clinic nearing completion, immediate use of rooms in present clinic building, also three rooms over post office ready for use, year's rent free. Excellent opportunity for qualified physician looking for general practice. Contact Mr. J. Welborn Johnson, P. O. Box 143, Roberta, Georgia.

Arlington, Georgia - Calhoun County - In need of a doctor-surgeon for practice in new excellently equipped 161 bed hospital located to serve Calhoun, Baker, Early and Clay counties. Office space and home available. Contact: Mr. Carter Ray, Arlington, Georgia. (Population 1,382).

Attapulgus, Georgia - Decatur County - Present doctor unable to practice on full scale; has clinic with waiting rooms for white and colored patients, x-ray, cardiogram, metabolism, pneumothorax, violet ray and laboratory equipment. Town is centrally located with access to hospitals. Present doctor will reserve working space in the clinic, will sell outright or lease the clinic at very nominal figure. Contact: Dr. Carl B. Welch, Attapulgus, Georgia. (Population 800).

Bremen, Georgia - Haralson County - Need an associate in field of obstetrics and gynecology. Completing a modern office building to house the group and about October 1st new 29 bed hospital should be in operation. Group consists of three physicians—2 in surgery and 1 in medicine and anesthesia. Would have all the work he could handle in ob and gyn. Contact: Dr. J. H. Pritchett, Jr., Bremen Hospital, Bremen, Georgia. (Population 3,500).

Jeffersonville, Georgia - Twiggs County - Only doctor in county is in his 70's and has been doing limited practice. Contact Mr. H. C. Swearingen, Jeffersonville, Georgia. (Population 1,000).

Woodbine, Georgia - Camden County - Small fully equipped and stocked office and clinic immediately available; ample office space, delivery room, laboratory (including x-ray), nursery, wards and private rooms; can be used as office, clinic or small hospital; 5 room wooden dwelling adjoins to hospital, available at \$35.00 per month or other houses for rent or sale; one other doctor in Woodbine. Doctor is needed now. Contact: Dr. Sam C. Atkinson, Waverly, Georgia. (Population 1,000).

When a location has been filled, please contact the Medical Association of Georgia, 875 West Peachtree St., N. E., Atlanta, Ga.

Rabies Danger Decreases

Georgia's dogs, cattle, and people have much less to fear from rabies today than ten years ago. It's going to cost less, too.

Through July, 1954, there have been 106 animal brains found to be infected compared with about 500 during the first seven months of 1944, according to Dr. L. E. Starr, State Health Department veterinarian. He says that there were 2800 human beings in Georgia who took the Pasteur treatment in 1944, while at our present rate, only about 500 people will need to take the antirabic treatment this year.

Dogs' brains are tested for rabies at the Health Department's central laboratory in Atlanta, as well as at branch laboratories at Macon, Albany and Waycross. County-municipal laboratories in Augusta, Columbus and Savannah also examine heads of dogs that are suspected of being rabid.

Dr. Starr says conservative cost figures on the preparation and distribution of antirabic vaccine for human use in Georgia, combined with cost of administration and value of farm animals that died of rabies in 1944 totaled not less than \$250,000. Comparable figures for 1954 are expected

not to exceed \$24,000, a saving of \$226,000 to tax payers of the state.

Only one person—four-year-old Darrell Hayes of Winder—in Georgia has died of rabies this year. In 1944 rabies claimed the lives of five persons in the state.

"Rabies is now at its lowest ebb in Georgia for many years. The disease is still present, however, in some areas. Therefore, it is essential that dog vaccination be maintained until the disease can be completely wiped out," Dr. Starr says.

Dr. Starr advises that if you have been bitten by a dog you suspect of being rabid, do not kill the dog but put him in a pen or tie him up. If the dog dies have the head examined and if it is found to have rabies, you still have time for treatment. Otherwise you will never know if the dog was infected with rabies and may have to take antirabic treatment unnecessarily. Foxes or other species of wild life cannot be handled, therefore, if bitten by one of these animals destroy it if possible and submit the head to a laboratory for examination.

MAG Council Meeting

Atlanta, September 19, 1954

THE THIRD MEETING of the 1954-55 Council of the Medical Association of Georgia was called to order by Chairman Cheves at 10 a.m., September 19, 1954, at the Academy of Medicine, Atlanta.

Present were Peter B. Wright, Augusta; Willard R. Golsan, Macon; Milford B. Hatcher, Macon; David Henry Poer, Atlanta; Lee Howard, Savannah; George R. Dillinger, Thomasville; W. G. Elliott, Cuthbert; J. W. Chambers, LaGrange; Mark S. Dougherty, Atlanta; D. Lloyd Wood, Dalton; Neal Yeomans, Waycross; W. Bruce Schaefer, Toccoa; and H. L. Cheves, Union Point. The following Vice-Councilors were present: Clarence B. Palmer, Covington; J. G. McDaniel, Atlanta; James M. Hicks, Brunswick; Charles T. Brown, Guyton; and Ralph W. Fowler, Marietta. Also present were William Harbin, Rome; Eustace A. Allen, Atlanta; David R. Thomas, Jr., Jr., Augusta; Thomas W. Goodwin, Augusta; Enoch Callaway, LaGrange; W. D. Hazlehurst, Macon; Charles H. Richardson, Sr., Macon; A. O. Linch, Atlanta; Chris J. McLoughlin, Atlanta; Edgar Woody, Jr., Atlanta; Charles S. Jones, Atlanta; Spencer Kirkland, Atlanta; John L. Chandler, Jr., Augusta; Mr. John Dunaway, Atlanta; Mr. Lafayette Davis, Atlanta; Mr. J. L. Kirkpatrick, Atlanta; Mr. Joe Bryant, Atlanta; and Mrs. Myrtice Mulligan, Mr. John F. Kiser and Mr. Milton D. Krueger.

The Invocation was read by David Henry Poer.

Council minutes for June 6th and Executive Council minutes for July 11th were read by Executive Secretary Krueger.

William Harbin asked that the Executive Committee of Council minutes be corrected to read that his appointment to the Executive Committee is in an advisory capacity. With this correction, the minutes stood approved as read.

David R. Thomas, Chairman, Insurance Board, reported on the two recent meetings of the Board, July 11th and August 8th.

Representatives of the three insurance companies—Provident Life and Accident Insurance

Company, Southern Life Insurance Company of Georgia and Commercial Insurance Company—requested approval of their life and health-and-accident insurance policies to be issued on a group basis. On a motion by Dr. Poer, all of these insurance matters were referred to the Insurance Board for consideration and action. It was also moved that the Insurance Board be empowered to act in conjunction with the Executive Committee on matters relating to the Association's endorsement of commercial insurance companies. This motion was approved.

Charles S. Jones presented the Insurance Board's Sub-committee report on Malpractice Insurance, for information only.

Report of the AMA Delegates of the 103rd Annual Meeting of the American Medical Association in San Francisco was given by Spencer Kirkland, for information only.

Requests for resolutions to be presented at the Miami meeting were called for by Eustace A. Allen. He also discussed plans to have the Georgian's present at the meeting give a breakfast for the Board of Trustees of AMA.

Proposal of AMA General Practitioner of the Year plans were presented by Charles H. Richardson. Mark Dougherty discussed the report of Dr. Richardson and made a motion that Council underwrite any expense that may be incurred, up to the amount of \$500.00, provided the Auditing and Appropriations Committee finds funds available.

David Henry Poer moved that a committee, to consist of C. H. Richardson as Chairman and W. D. Hazlehurst, George A. Alexander and Mark Dougherty as members, work out plans described by Richardson. This motion was duly seconded and adopted.

Other Reports

Committee on Constitution and By-Laws—Chairman Chambers stated the committee met July 11th in Augusta and is in the process of revising the MAG Constitution and By-Laws.



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Georgia Baptist Hospital

Piedmont Hospital

St. Joseph's Infirmary

Emory University Hospital

Ponce de Leon Infirmary

Membership Classification—Chairman Dougherty described the work of the committee in making MAG membership classifications conform with AMA membership categories. This report was referred to the Committee on Constitution and By-Laws.

Committee on Auditing and Appropriations—Chairman Chambers reported that the Association is operating within its budget. He reported the bank balance on August 31, 1954, was \$31,880. Dr. Chambers moved that Council approve travel expenses for the third AMA Delegate to the Miami meeting, and he also asked for approval for increase in expenditure in travel allowance. Both of these motions were duly seconded and adopted.

Professional Conduct Committee—Chairman Callaway reported the results of two recent meetings of the Professional Conduct Committee, for information only.

Building Improvement—A. O. Linch of the Fulton County Medical Society expressed the Society's desire to cooperate with the MAG in the construction of a Council room for the Association. It was suggested that Fulton County Medical Society proceed with this work on a 50-50 basis with the MAG. Payment of MAG share to be determined by the Executive Committees of both organizations.

American Medical Education Foundation—Chairman Chandler reported results of a July meeting of the Committee in Macon. He reported that the committee plans certain publicity in the Journal and will contact all MAG members in November for contributions to AMEF.

Local Arrangements Committee—Chairman Goodwin reported on plans for the 1955 Annual Session to be held May 1-4, Augusta. He recommended that in the future, the House of Delegates consider putting the Annual Session on a different financial basis whereby the local society does not suffer undue financial burdens in entertaining the Association. He recommended that each physician in attendance at an Annual Session be sold a book of tickets that will cover the cost of the Session.

MAG Journal—Editor Woody asked for approval of 13 Contributing Editors recently appointed to the *Journal* staff.

These physicians are: Arthur J. Merrill, Atlanta; Lester Rumble, Jr., Atlanta; Patrick C. Shea, Jr., Atlanta; William H. Lippitt, Savannah; Charles W. Hock, Augusta; Henry H. Tift, Macon; Arthur M. Knight, Jr., Waycross; Robert H.

Vaughan, Columbus; Herbert S. Alden, Atlanta; Charles S. Jones, Atlanta; Peter L. Scardino, Savannah; George T. Nicholson, Cornelia; and Thomas Findley, Augusta.

Dr. Poer moved that recommendations of Dr. Woody be referred to the Publications Committee for action. The motion was seconded and adopted.

The Council was recessed for lunch at 12:45.

The recessed meeting of Council was called back to order at 2 p.m. by Chairman Cheves.

Report of MAG Members of the Joint Policy Committee—Enoch Callaway reported some of the aspects of the proposed Eugene Talmadge Memorial Hospital policy for the information of Council. The proposed policy was then discussed at some length by Council.

Various aspects of the proposed policy were discussed by D. Lloyd Wood, Charles H. Richardson, Mr. John Dunaway (MAG attorney, who reported on legal aspects of the policy), and Thomas W. Goodwin, who described the background of the projected policies from the point of view of the State Board of Health and the State Board of Regents. Peter B. Wright discussed the controversial aspects of the projected policies in the Pund letter from the point of view of the Medical Association of Georgia and the American Medical Association. Dr. Wright expressed confidence in the Joint Policy Committee's ability to find an equitable solution to the problems concerned with the operation of the Talmadge Hospital in conjunction with the Medical College of Georgia.

Dr. Poer then offered a substitute motion which was accepted by George Dillinger. The substitute motion was as follows:

That Council disapproves the corporate practice of medicine, and, Council, acting upon legal advice that the plan for the operation of the Talmadge Memorial Hospital as described in the Pund letter puts the Talmadge Hospital in the corporate practice of medicine, hereby disapproves of this plan.

This motion was for the guidance only of the MAG members on the Joint Policy Committee which plans to meet on Sunday, September 26, 1954, in Augusta.

The motion was duly seconded and carried by a vote of seven to three.

Dr. Callaway requested of Council further instructions for the three MAG members on the Joint Policy Committee and Mark Dougherty moved as follows:

That it is the feeling of the Council of the Medical Association of Georgia that the participation of physicians in such a plan as described in Dr. Pund's letter would be considered unethical.

The motion was duly seconded and carried.

Miscellaneous Business

The reissuance of original charters as requested by Polk, Ware and Wayne County Medical Societies was approved.

A request by a cigarette company to provide samples at the Annual Session was referred to the Local Arrangements Committee.

Information concerning the possibilities of a shipboard annual session meeting, sponsored by the Muscogee County Medical Society, was presented for information only.

New Business

MAG Auditing and Appropriations Committee

Chairman Chambers requested that all officers, committee chairmen and interested parties submit requests for appropriations for the 1955 MAG budget within the next 30 to 60 days to Dr. J. W. Chambers, LaGrange, Georgia. The Executive Secretary was authorized to correspond with the above parties in this connection.

Three invitations for the December Council meeting were issued from Thomasville (George R. Dillinger); Macon (Milford B. Hatcher) and Atlanta (Chris J. McLoughlin). On a motion by Dr. Poer, these requests were referred to the Executive Committee for action.

The Executive Secretary was directed by Council to write a letter in behalf of the members of Council to Dr. and Mrs. Eustace A. Allen, Atlanta, for their gracious hospitality extended Council members on the occasion of this meeting.

Council was adjourned at 3:40 p.m.

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A half-million-dollar “watchdog” stands guard over every person who has an operation in any one of 3,000 hospitals—and it doesn't cost the patient a penny.

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They know every detail of the operation and the people who perform it, and can give a step-by-step accounting to representatives of five of “the most powerful medical organizations in the world,” the article said. For the patient, this means that “every effort is being made to assure him of the best possible medical care.”

This “round-the-clock” watcher of hospital patients is the little-publicized Joint Commission on Accreditation of Hospitals. It is backed by the A.M.A., the American Hospital Association, the American College of Surgeons, the American College of Physicians, and the Canadian Medical Association. They spend nearly half a million dollars a year keeping U. S. and Canadian hospitals operating at top efficiency.

Field representatives tour the country making routine inspections of the more than 3,000 hospitals on the commission's approved list, and of

many others seeking its approval. Among the patient safeguards to be found in approved hospitals are fireproofing, adequate room for each patient and isolation space for contagious disease patients, proper diagnostic and treatment facilities under competent medical supervision, and emergency lighting in case of power failure and sterile conditions in operating rooms.

The approved hospital keeps records of anesthetic or drugs given, and any specimen taken from the body during operation is examined and recorded. Approval also depends on constant checks and periodic reviews by the hospital staffs of what is done in their institutions. Rates of mortality, unimproved cases, and Caesarean births must be low.

Irregularities of any of these standards might mean loss of approval. Hardly any hospital can meet all the requirements; a score of 75 is needed for full approval, which this year was given to 3,418 of the 7,500 hospitals in the U. S. and Canada. Some other hospitals may meet the standards but have not yet sought commission approval under its voluntary plan of accreditation.

The commission hopes that ultimately every hospital in the two countries will be brought under the program. Its goal is for a standardized program of high quality for all hospitals.

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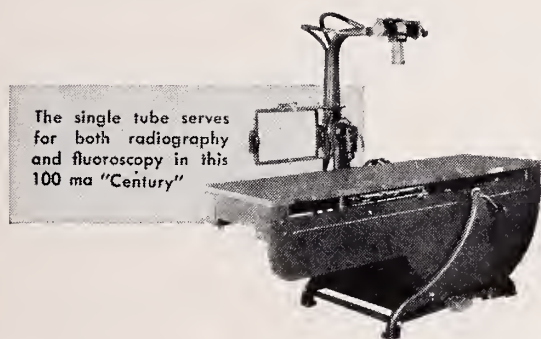
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1. Werner, A.: *Acta endocrinol.* 13:87, 1953.

2. Malleson, J.: *Lancet* 2:158 (July 25) 1953.

3. Goldzieher, M. A., and Goldzieher, J. W.: *Endocrine Treatment in General Practice*, New York, Springer Publishing Company, Inc., 1953, p. 23.



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ANNOUNCEMENTS

Diabetes Week—November 14-20, 1954.

British Medical Association, Jamaica Branch—Kingston, Jamaica, B.W.I., December 4, 1954, following the Interim Meeting of the AMA in Miami. Further information will be available at Information Desks at the Miami meeting.

American College of Chest Physicians, Interim Session—Miami Beach, Fla., November 28-29, 1954, at the Delano Hotel. For further information write to Mr. Murray Kornfield, Executive Director, American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Illinois.

Sixth Congress Pan-American Academy of General Practice—Lima, Peru, February 11 to 25, 1955. The number of invitations is limited. Application should be made to Arturo Martinez, M.D., Secretary, Pan-American Academy of General Practice, 54 East 72nd Street, New York 21, N. Y.

American Congress on Obstetrics and Gynecology—Palmer House, Chicago, Ill., December 13-17, 1954. For information write to the Sixth American Congress on Obstetrics and Gynecology, 116 South Michigan Ave., Chicago 3, Ill.

South Atlantic Association of Obstetricians and Gynecologists—Williamsburg, Va., February 10, 11 and 12, 1955. For information write to Dr. C. H. Mauzy, Secretary-Treasurer, Bowman-Gray School of Medicine, Winston-Salem, N. C.

Georgia Society of Ophthalmology and Otolaryngology—General Oglethorpe Hotel, Savannah, Ga., March 11-12, 1955. Speakers will be: Dr. Francis H. Adler, Philadelphia; Dr. J. W. McCall, Cleveland; Dr. J. A. Hilger, St. Paul; Dr. Walter H. Fink, Minneapolis; Dr. James H. Allen, New Orleans; and Dr. P. E. Ireland, Toronto.

For further information contact Dr. Alton V. Hallum, 490 Peachtree St. N.E., Atlanta, Ga.

Seventh Annual Convention International Academy of Proctology—Plaza Hotel, New York City, March 23 to 26, 1955. All physicians and their wives are cordially invited. For information write to the International Academy of Proctology, 147-41 Sanford Ave., Flushing, New York.

The National Foundation for Infantile Paralysis announces the availability of a limited number of fellowships to psychiatrists who are interested in the emotional problems of the physically handicapped, particularly of the poliomyelitis patient with respiratory difficulties. To be eligible, physicians must have completed two years of graduate training in psychiatry acceptable to the American Board of Psychiatry and Neurology, be U. S. citizens and be in sound health. Stipends range from \$3,600 to \$7,000 a year. For information, address: The National Foundation for Infantile Paralysis, Division of Professional Education, 120 Broadway, New York 5, N. Y.

American Board of Physical Medicine and Rehabilitation—The next examinations for the American Board of Physical Medicine and Rehabilitation will be held in Philadelphia, June 5 and 6, 1955. Applications must be filed by March 1, 1955. Address the Secretary, Dr. Earl C. Elkins, 30 N. Michigan Ave., Chicago 2, Ill.

Van Meter Prize Award—The American Goiter Association offers \$300.00 and two honorable mentions for the best essays submitted concerning original work on problems related to the thyroid gland. The award will be made in April 1955; entrance deadline is January 15, 1955. For further information write to the Secretary, John S. McClintock, M.D., 149½ Washington Ave., Albany, N. Y.

SOCIETIES

The SECOND DISTRICT MEDICAL SOCIETY met Thursday October 7, 1954, at the Elks Club, Tifton, Ga. Those participating in the Scientific Session were as follows: Hugh Sealy, Macon—"Diagnosis of Congenital Heart Disease"; R. G. Ellison,

Augusta—"Surgical Treatment of Acquired Heart Disease"; and T. L. Ross, Macon—"Heart Disease in General Practice". A social hour and dinner at the Alpine Restaurant followed the meeting. Officers of the Second District Medical Society are John F. McCoy, Moultrie, president; Carl S. Pittman, Jr., Tifton, vice-president; and Julian B. Neel, Thomasville, secretary-treasurer.

The FOURTH DISTRICT MEDICAL SOCIETY met September 23, 1954, in Newnan with its president, G. D. Floyd of Griffin, presiding. John G. Wells, Newnan, addressed the group on "Current Concepts of Hypertension."

The SEVENTH DISTRICT MEDICAL SOCIETY met September 29, 1954, at the Calhoun Elks Club with R. D. Walter, president, presiding. Members of the Gordon County Medical Society were hosts. Those presenting scientific papers were as follows: W. D. Hall, Calhoun—"Retropertitoneal Sarcoma"; John M. McGehee, Cedartown—"Electrolyte Balance in the Small Hospital"; Byron H. Steele, Fairmount—"Delayed Reaction to Dicumarol"; J. Harris Dew, Atlanta—"Thyroiditis"; and Crawford Brock, Rome—"Traumatic Hand Injuries". Officers of the district society are R. D. Walter, Calhoun, president; W. U. Hyden, Trion, president-elect; and Ralph N. Johnson, Rome, secretary-treasurer.

The EIGHTH DISTRICT MEDICAL SOCIETY met October 12, 1954, at the King and Prince Hotel, St. Simons Island, Ga. The meeting was called to order by President H. T. Atkins, Waycross. Those participating in the Scientific Session were: R. E.

Rice—"A New Concept of Burn Therapy"; E. R. Jennings—"Surgery of the Hand"; Dr. Hightower—"Diagnosis and Management of Certain Chest Problems"; and E. R. Pund—"Report on Eugene Talmadge Memorial Hospital." A Social Hour and dinner followed the scientific program and business session. The society voted to contribute \$400 to AMEF. Officers elected at the meeting were as follows: Van Bennett, Valdosta, president; Joe Mercer, Brunswick, vice-president; and Sage Harper, Douglas, secretary-treasurer.

CHEROKEE-PICKENS MEDICAL SOCIETY held its regular monthly meeting on September 24 in Canton. H. D. Meaders, Marietta, head of Obstetrics at Kennestone Hospital, was the guest speaker. His topic was "The Rh Factor in Obstetrics".

CLARKE-MADISON-OCONEE MEDICAL SOCIETY met recently in Waycross. "Food Allergy in Infants" was the subject for the scientific program. The program was presented by Neal Yeomans with Harold W. Muecke and C. M. Massey, discussants. The Ware County Society presented a public medical forum on September 21 on "Nervousness". Physicians participating were M. McGoogan, Chairman, Arthur M. Knight, moderator, W. B. Bates and Sam Victor.

PERSONALS

OSLER A. ABBOTT, Atlanta, spoke at the recent meeting of the Tenth District Medical Society of North Carolina which was held in Asheville. The scientific program consisted of a symposium on malignant diseases with a general approach to the recognition and management of malignancy.

Mr. and Mrs. Iris Jackson Whitworth of Gainesville have announced the engagement of their daughter, Miss Elizabeth Irwin Whitworth to HEWLETT EDWIN ADERHOLT, JR., of Jefferson. Dr. Aderholt is a graduate of the University of Georgia and the Medical College of Georgia. He received his M.D. degree in 1953 and served his internship at Macon City Hospital. The wedding will be solemnized on November 26th in Gainesville.

ERWIN ALLEN, Milledgeville, was named a vice president of the Southern Psychiatric Association at their convention in October.

Dr. and Mrs. H. DAWSON ALLEN, JR., Milledgeville, have returned from an interesting trip to Rome, Italy, where he attended the International Medical Congress, and Germany where they visited their son, Lt. George Allen, U. S. Medical Corps, and Mrs. Allen. For further news of Dr. Allen, see "Association Mail."

T. J. ARLINE and W. A. WALKER, Cairo, were given special recognition recently by the many people of the community whom they have served in years past. The two 88 year old retired physicians received letters of appreciation from the Cairo Kiwanis Club and were recognized by the First Methodist Church on one Sunday in September.

In the film, "Fighting Lady," the ship's doctor for the airplane carrier is in reality a Georgian—or at least the original was FRED BENNETT, JR., Buena Vista. Dr. Bennett is portrayed by Walter Pidgeon on the screen.

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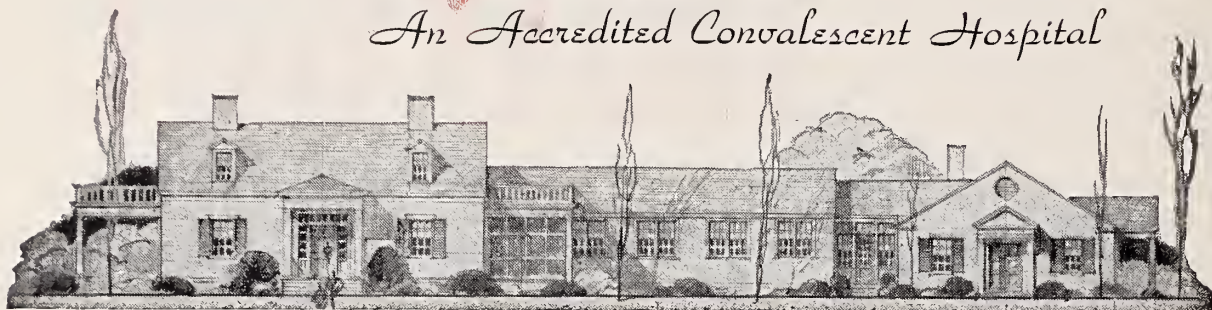
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ternational College of Surgeons at the 19th Annual Congress in Chicago of the College's U. S. section. Qualified fellows of the College inducted were JOHN GORDON BRACKETT, Atlanta; CHARLES IVERSON BRYANS, Augusta; HERMAN LAMAR DISMUKES, Ocilla; and ANDREW KYME TEMPLES, Spartanburg, S. C. Named to associate memberships were HARRY LANGDON CHEVES, Union Point; DAVID B. FILLINGIM, Savannah; JOHN PHINIZY HITCHCOCK, Augusta; FRANKLIN PENDEGRASS HOLDEN, Eastman; ROBERT CLIFFORD MONTGOMERY, Butler; C. L. JAMES ROPER, Jasper; and DAVID CALHOUN WILLIAMS, JR., Augusta. RICHARD TORPIN, Augusta, spoke at a session of the Congress.

J. B. BYNE, JR., Waynesboro, was recently chosen "Professional Man of the Week" by the citizens of Waynesboro. Dr. Byne is a native of Waynesboro and a graduate of the University of Georgia and the Medical College of Georgia. He interned for one year at the University Hospital. He is a deacon of the First Baptist Church, a member of the Rotary Club and representative for the first congressional district on the state health board.

A distinguished father and son team occupied a prominent place in the festivities that accompanied the 100th anniversary of the birthday of Emory University School of Medicine. F. PHINIZY CALHOUN, SR., Atlanta, was awarded the honorary degree of Doctor of Laws; F. PHINIZY CALHOUN, JR., Atlanta, had the honor of placing the hood over the shoulders of his father. Dr. Calhoun has practiced in Atlanta for more than 50 years since his graduation from Emory in 1904, and he is a member of the executive committee of the University's board of trustees. Dr. Calhoun, Jr. is chairman of the Department of Ophthalmology at Emory.

WILLIAM R. CHAMBERS, Atlanta, was made a qualified fellow of the International College of Surgeons at their recent meeting in Chicago.

ELLISON R. COOK, Savannah, is the new president of the Georgia Heart Association succeeding J. C. MASSEE, Atlanta. LAMONT HENRY, Atlanta, was named president-elect at the recent Sixth Annual Meeting of the Georgia Heart Association held in Savannah.

J. KENNETH COOKE, Trenton, has announced plans to build a new clinic equipped for minor surgery and obstetrics, besides housing his office.

In making the announcement, Dr. Cooke expressed the feeling that the clinic would fill a definite need in Dade County.

M. K. BAILEY, Atlanta, announces the association of G. THOMAS COWART with him in the practice of urology, 1106 Medical Arts Building, Atlanta.

HARRY EVANS, Newington, has recently opened a clinic in Newington. Dr. Evans decided to return to practice when the town was left without a physician at the death of E. E. DOWNING. He has been living there for several years but was not actively engaged in the practice of medicine.

ALEX L. FINKLE, formerly of Savannah, announces the location of his office at 54 Sutter Street, San Francisco, Cal.

FRANK GIBSON, Bainbridge, announces the resumption of his practice in Bainbridge after serving with the Navy Medical Corps for the past 18 months.

ROBERT B. GREENBLATT, Augusta, read a paper recently before the New Jersey Academy of General Practice in Newark. Subject of the paper was "Hormonal Therapy and Office Gynecology."

THOMAS HAMILTON, Buchanan, has recently opened offices in Buchanan. He is a native of Winder, and according to the Haralson County Tribune, the people of that section have greeted him with open arms.

Four faculty members of the Medical College of Georgia have received grants totalling \$33,692 from the National Institutes of Health for research projects. WILLIAM F. HAMILTON, chairman of the physiology department, received \$23,000 for "Physiological and Clinical Cardiovascular Studies"; W. KNOWLTON HALL, associate professor of biochemistry, and ROBERT B. DIENST, professor medical micro-biology, \$5,400 for "A Study of an Unidentified Growth Factory"; and CHESTER H. HEUSER, professor of microscopic anatomy, \$5,292 for "Morphological Survey of Early Human Embryos."

DANIEL D. HANKEY, ARTHUR M. PRUCE, PAUL REITH, CHRISTOPHER J. MCLOUGHLIN and VERNON POWELL, Atlanta, discussed problems of arthritis on a television panel program recently; the program was a feature of the 1954 Arthritis Fund Drive in Atlanta.

LYLE F. HERRMANN, Hapeville, a former commander in the Medical Corps of the U. S. Navy,

has recently gone into the private practice of medicine in Hapeville. Dr. Herrmann is associated in practice with his brother-in-law, L. M. HEWITT, at 757 Virginia Avenue.

J. E. JOHNSON, Elberton, celebrated his 92nd birthday on September 14th. Dr. Johnson practiced for nearly half a century in Elbert County before his retirement in 1944. He has the distinction of having performed the first appendectomy in Elbert County.

FORREST D. JONES, Atlanta, finished his residency in pediatrics at Grady Hospital on August 31st and is now associated with T. F. DAVENPORT in the practice of pediatrics in Atlanta. Dr. Jones is a graduate of Emory University and the Medical College of Georgia. He received graduate training at Crawford Long Hospital in Atlanta, Children's Hospital in Cincinnati and Grady Hospital in Atlanta.

J. P. JONES, of Louisville, has recently opened offices in Wrens with office hours in Wrens on Tuesdays and Thursdays.

JAMES B. KAY, Byron, Georgia's Practitioner of the Year, was the inspiration recently for a full page feature article in the Macon Telegraph and News. Sharing the spotlight with Dr. Kay were Mrs. Kay and their two sons, J. B. KAY, JR., Augusta, and Ferd Kay, a first year student at the Medical College of Georgia.

WILLIAM R. KING, JR., Griffin, was made a fellow of the International College of Surgeons at the annual meeting of that organization in Chicago. Dr. King is also a fellow in the American College of Surgeons and a fellow of the Southern Surgical Congress. He is a graduate of Emory University School of Medicine.

WILLIAM H. KISER, JR., Atlanta, spoke at the September meeting of the Greater Atlanta Chapter of the Georgia Association for the Help of Retarded Children. His subject was "The Retarded Child in the Family Group." Dr. Kiser is a member of the advisory board of the Georgia association and serves on the screening board for the Fairhaven School for Mentally Retarded Children.

JOHN R. LEWIS, JR., Atlanta, appeared on the program of the International College of Surgeons in Chicago. His paper was on the "Management of Facial Scars."

DEVEREUX H. LIPPITT, II, Savannah, has recently bought the Swedenborgian Church at the southeast corner of Drayton and Huntingdon streets to establish a medical clinic there. Dr. Lippitt is moving to Savannah from Warwick, Va.

LEONARD T. MAHOLICK, Columbus, spoke recently at the Lions Club meeting on "The Mentally Ill, Who Cares?"

LESTER J. MARTENS, Rome, has completed a two year tour of duty with the U. S. Air Force and has opened an office in Rome. Dr. Martens is a graduate of Columbia University College of Physicians and Surgeons at the New York Medical Center. He served his internship and three years residence in internal medicine and cardiology at Bellevue Medical Center. His office is located in the Doctors Building, 200 East Third Street.

J. D. MARTIN, JR., Atlanta, is chairman of the committee to administer the scholarship fund which has been established in memory of the late Cyrus W. Strickler, Sr. The scholarship is to be given annually to students in the Emory University School of Medicine. Other members of the committee are F. M. ATKINS, co-chairman; T. T. BLALOCK, A. O. LINCH, R. F. MADDOX, SR., F. C. OWENS, SR., and W. C. WARREN, JR., all of Atlanta.

WALTER MARTIN, Dawson, has been elected head of the medical staff of the Terrell County Hospital. He succeeds ERNEST DANIEL who recently resigned to move to Augusta. F. E. SIMS is vice-chief of staff and BILLY MARTIN, secretary-treasurer.

ROBERT E. PERRY, Valdosta, has retired as president of the South Georgia Medical Society and turned the gavel over to the vice-president, JESSE L. PARROTT, of Hahira. Dr. Perry left his practice in Valdosta in June to enter Duke University Hospital where he is a member of the resident staff on pathology.

JOSEPH B. MERCER, Brunswick, announces the association of W. O. INMAN, JR., in the general practice of medicine and surgery with offices in WGIG Building, 1514 Union Street.

CLIFFORD MONTGOMERY, II, Butler, is too young to remember the horse and buggy days of the general practitioner, but, as far as he is concerned, even the automobile is outmoded in the practice of medicine. In his green-and-white Tri-Pacer, Dr. Montgomery has become a familiar

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Streptomycin and dihydrostreptomycin in equal parts


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	Mild	Moderate	Total
Streptomycin	12	6	18
Dihydrostreptomycin	6	0	6
Distrycin	0	0	0

	Cochlear damage % of patients		
	Mild	Moderate	Total
Streptomycin	0	0	0
Dihydrostreptomycin	12	3	15
Distrycin	0	0	0

*Heck, W.E.; Lynch, W.J., and Graves, H.L.: *Acta oto-laryng.* 43:416, 1953.

Distrycin dosage is the same as for streptomycin. In tuberculosis the routine dose is 1 Gm. twice weekly, in conjunction with daily para-aminosalicylic acid or Nydravid (isoniazid). In the more serious forms of tuberculosis, Distrycin may be given daily, at least until the infection has been brought under control.

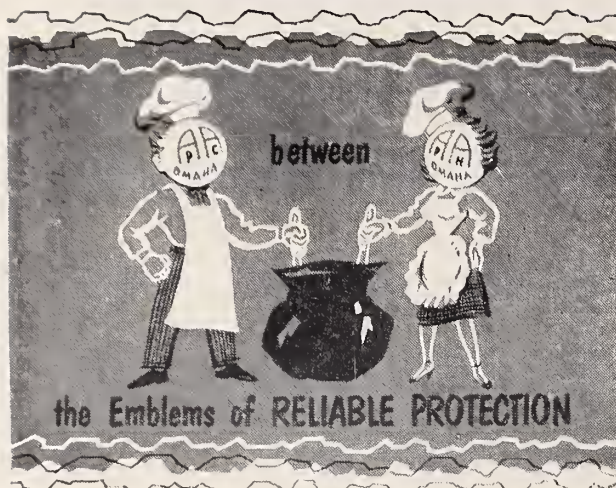
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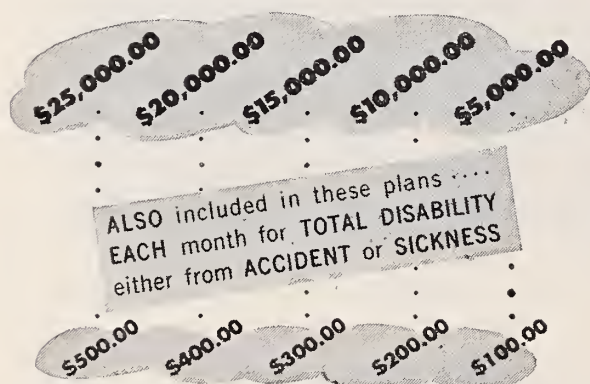
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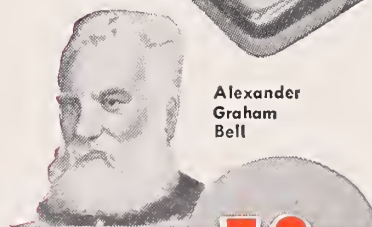
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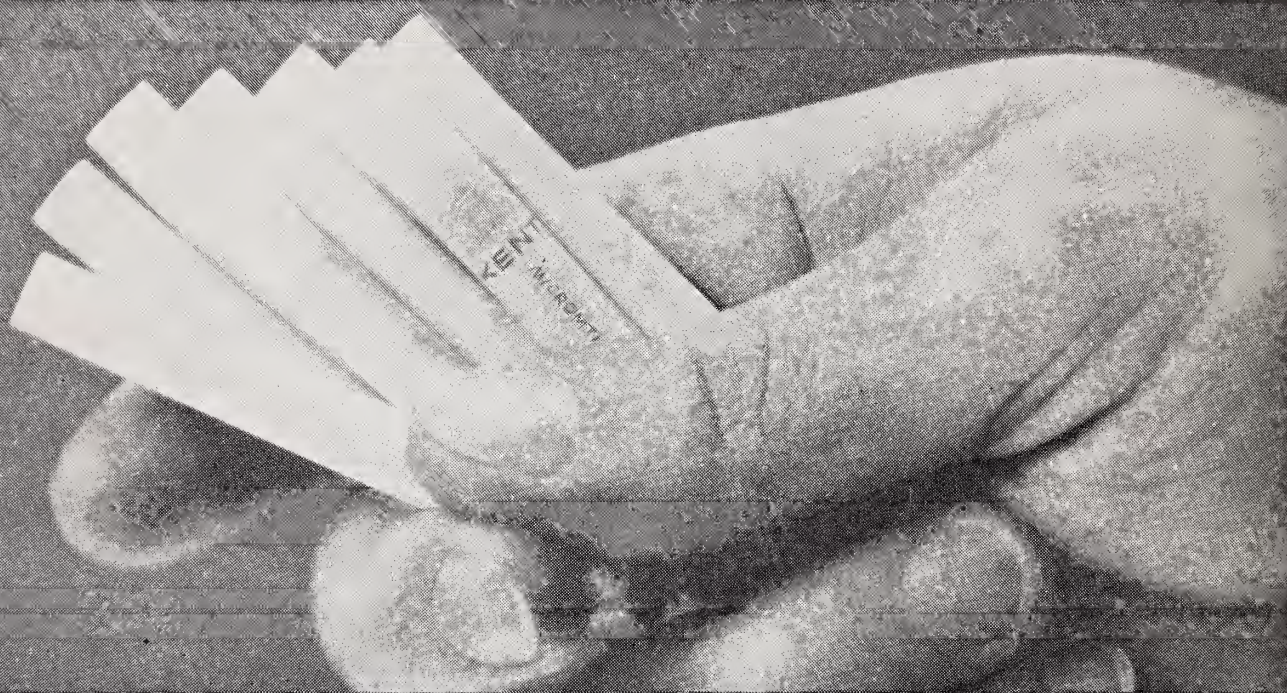
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The Pedigreed Hearing Aid

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The answer is simply this: Among today's nine brands of filter cigarettes, KENT, and KENT alone, has the *Micronite Filter*...made of a pure, dust-free material that is so safe, so effective it has been selected to help filter the air in hospital operating rooms.

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Kent

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for the greatest protection in cigarette history

sight at all the airports in the Chattahoochee Valley. He was also recently made an associate member of the International College of Surgeons at their meeting in Chicago.

HARVEY M. NEWMAN, III, Gainesville, announces the opening of his office at 660 East Spring Street, for the practice of pediatrics. Dr. Newman recently completed two years of military service. He is a graduate of the Medical College of Georgia.

SAMUEL W. NORWOOD, Atlanta, announces the association of DAVID G. STROUP in the practice of obstetrics and gynecology.

RUFUS PAYNE, Augusta, spoke to the Brunswick Rotary Club about the functions of the new Georgia medical center at Augusta.

Recently at the Auburn Methodist Church a "Dr. Pharr Appreciation Day" honored L. P. PHARR; the sermon's theme was "Service to Your Fellow Man"; it was built around the life of the physician. The day's offering was dedicated to Dr. Pharr and will be used toward the purchase of new pulpit furniture for the new Methodist Church.

On September 1st, DON PITTARD, a native of Atlanta, established his office for the practice of internal medicine in association with BRUCE SHAEFER and JOHN DERRICK in the Medical Arts Building on N. Sage Street in Toccoa. Dr. Pittard received his M.D. degree from Emory University School of Medicine.

R. C. RICHARDSON, Albany, has opened offices for the practice of eye, ear, nose and throat medicine at 506 Broad Avenue, Albany. Dr. Richardson is a native of Albany, Kentucky; he is a graduate of the University of Louisville School of Medicine and his residency training was at New York University, Bellevue Medical Center.

On September 23rd Atlanta physicians and physicians of 22 other cities saw a closed circuit telecast on the management of high blood pressure sponsored by the American College of Physicians and Wyeth Laboratories. CARTER SMITH, Atlanta, governor of the American College of Physicians for the state of Georgia, served as local chairman.

HERSCHEL A. SMITH, Americus, has been made a fellow in the International College of Surgeons.

Recent faculty appointments at the Medical

College of Georgia include two new departmental chairmen—LELAND DOUGLAS STODDARD and FRANK QUATTLEBAUM. Dr. Stoddard has assumed his duties as professor of pathology and head of the Pathology Department of the college, but Dr. Quattlebaum will not join the faculty until September of 1955, as professor of surgery and chairman of the Surgery Department. Dr. Stoddard is a native of Hillsboro, Ill., a graduate of DePauw University and Johns Hopkins University School of Medicine. Dr. Stoddard has taught at Duke University and Kansas Medical School. Dr. Quattlebaum is a native of Fargo, Ga., and a graduate of the Medical College of Georgia. Dr. Quattlebaum received graduate training at the University of Minnesota and the Mayo Clinic. He has been a clinical instructor in surgery at the University of Minnesota Medical School.

Two members of the faculty of the Medical College of Georgia, THOMAS P. FINDLEY and V. P. SYDENSTRICKER, are on the board of examiners of the American Board of Internal Medicine and have recently returned from New York where they conducted examinations for prospective members of the Board.

HUGH S. THOMPSON, Swainsboro, has recently moved to Twin City. Dr. Thompson is a graduate of Emory University School of Medicine and has had two years training in surgery at the Richmond Medical College, Richmond, Va.

JAMES LACHLISON THOMSON, Eastman, has moved to Darien, Ga. He opened his offices in the J. B. Mallard Building on Broad Street in September. Dr. Thomson is a graduate of Emory University School of Medicine; he interned at Grady Memorial Hospital, Atlanta, and has practiced in Eastman since 1941.

J. K. TRAIN, JR., Savannah, is head of the medical division for the 1954-55 United Community Appeal in Savannah. As chairman of the medical division, Dr. Train supervises the solicitation of all physicians and their office staffs in the city and county.

JAMES R. WALLIS, Lovejoy, celebrated his 80th birthday on October 1, 1954, at a surprise party given him by Clayton County Health Department.

HOKE WAMMOCK, Augusta, delivered a paper at the meeting of Cancer Coordinators at the annual convention of the Association of American Medical Colleges in French Lick, Ind. The title

of the paper was "What the Cancer Teaching Grant has Meant in Development of a Research Laboratory."

SEYMOUR P. WEINBERG, Atlanta, announces the reopening of his office at 704 Piedmont Avenue, N.E., with practice limited to obstetrics and gynecology.

HOWARD J. WILLIAMS, Macon, announces the opening of his office at 745 Pine Street with practice limited to the care of infants and children.

RICHARD K. WINSTON, Valdosta, has been named head of the Professional Division of Lowndes County United Fund-Red Cross Campaign. R. L. STUMP, JR., is the vice-chairman in charge of solicitation of physicians.

DEATHS

WILLIAM STOKES GOLDSMITH, Atlanta, 85, died October 23, 1954, from injuries sustained in a fall. Dr. Goldsmith was born in Rome, Ga., on August 4, 1869, and moved shortly thereafter to Stone Mountain where he maintained a home until his death. He and Mrs. Goldsmith resided at the Colonial Terrace Hotel.

Dr. Goldsmith graduated from the Atlanta Medical College with the class of 1892. He began his practice as assistant to the late Willis Westmoreland, Jr. In 1906 he and William Simpson Elkin established the famous Elkin-Goldsmith Sanitarium.

Dr. Goldsmith was a member of the Southern Surgery and Gynecology Association, a fellow of the American College of Surgeons, and past president of the Medical Association of Georgia and

PETER B. WRIGHT, Augusta, attended the recent meeting of the American Fracture Association in Houston, Texas. Dr. Wright read a paper on "Fractures of the Lower End of the Radius" and participated in a panel discussion on "High Femoral and Intertrochanteric Fractures." Dr. Wright also spoke at the Fourth Annual Meeting of the Easter Seal Society of the Georgia Society for Crippled Children which was held in Macon October 21.

J. D. ZACHRY, Gray, Jones County's only physician who has practiced more than 40 years, recently observed his 72nd birthday. Dr. Zachry began his active practice in the county in 1911 and since then has been credited with delivering more than 2,000 babies.

of the Fulton County Medical Society. He was a 32nd degree Mason, a Shriner, charter member of the Druid Hills Golf Club and a member of the First Presbyterian Church. Dr. Goldsmith was married to Miss Grace Boyd in 1898. Surviving, besides his wife, are a daughter, Mrs. Charles H. Cox, Atlanta, and two grandchildren.

CHARLES H. PAINE, Atlanta, 67, died at his home, 1942 Lullwater Road, September 4, 1954. Dr. Paine was born in Valdosta, but he had made Atlanta his home since 1919. He was still active in his medical practice at the time of his death.

Dr. Paine was a member of Druid Hills Church of Christ.

Surviving are his wife; a daughter, Mrs. W. P. Deese of Nashville, Tenn.; sons, Dr. Charles H. Paine, Jr., of Chattanooga, and Mr. Harding Paine of Atlanta.

Council on Rural Health Prepares Brochure

Ways the AMA's Council on Rural Health can help you and your community "help yourself to better health" are neatly spelled out in an attractive new brochure prepared by the Council. Stressing the theme that "voluntary self-help and co-operative effort will solve most—if not all—of the health problems of any community," the

booklet briefly outlines the Council's purposes, history and activities.

The brochure will be distributed (about Nov. 1) to state medical society rural health committees, agricultural and farm leaders, educators and others interested in the field. Additional copies may be secured upon request to the Council.



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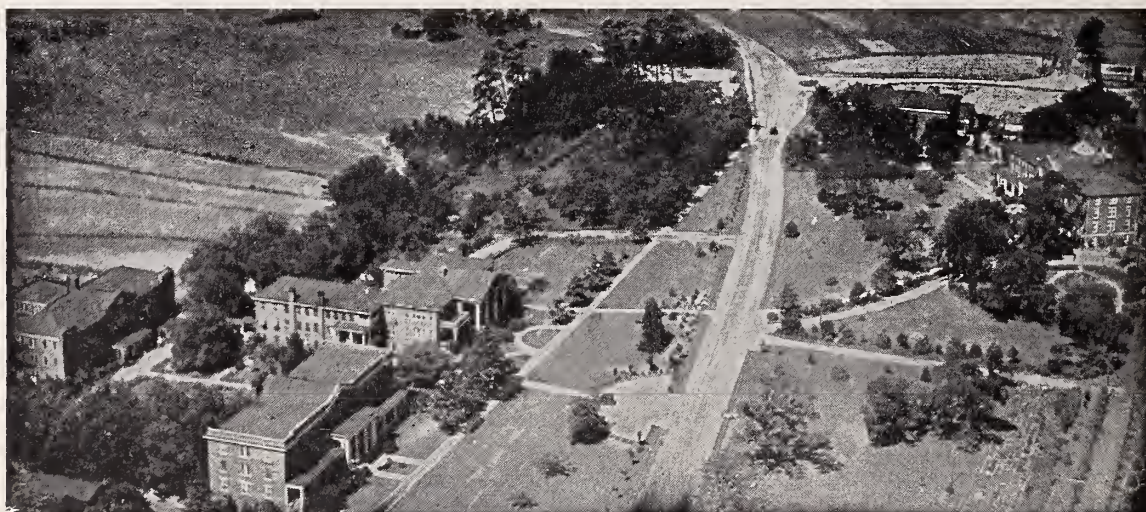
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City View Sanitarium

*For the diagnosis and treatment of
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BECAUSE THERE'S NO DELAY FROM AN ENTERIC COATING, your patient gets high, inhibitory blood levels within 2 hours—instead of 4-6 as before. Peak concentration at 4 hours, with significant levels for 8 hours.

USE FILMTAB ERYTHROCIN STEARATE against the cocci . . . and especially when the organism is resistant to other antibiotics. Low in toxicity—*it's less likely to alter normal intestinal flora than most oral antibiotics.* Conveniently sized (100, 200 mg.) in bottles of 25 and 100. **Abbott**

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The JOURNAL of the **MEDICAL ASSOCIATION OF GEORGIA**

875 West Peachtree, N. E.
Atlanta, Georgia

MANUSCRIPTS

Articles are accepted for publication on the condition that they are contributed solely to this *Journal*. Manuscripts should be typewritten, double-spaced and the original and two copies should be submitted. Receipt of manuscripts will be acknowledged and unused manuscripts returned. Used manuscripts will be returned only if requested.

STYLE

Ordinarily articles should not exceed 3,000 words. Only under exceptional circumstances will articles of over 4,000 words be published. Footnotes, bibliographies and legends should be typed on separate sheets, double-spaced. Bibliographies should conform to the style of the Quarterly Cumulative Index published by the American Medical Association—i.e., name of author, title of article, name of periodicals with volume, page, month, day of month if weekly and the year. They should be listed in alphabetical order and numbered in sequence. Example: 1. Jones, S. R.: Spontaneous Epistaxis, *Arch. Int. Med.*, 36:434 (Dec.) 1946.

NEWS NOTES

District and County Medical Societies, Association members and readers are invited to send in any news items of general concern to members of the Medical Association of Georgia.

REPRINTS

Requests for reprints should be made direct to Mr. T. D. Thompson, Franklin Printing & Mfg. Co., 675 Drewry Street, N.E., Atlanta, Georgia. Reprints must be ordered within 30 days after publication, since all type will be destroyed after that time.

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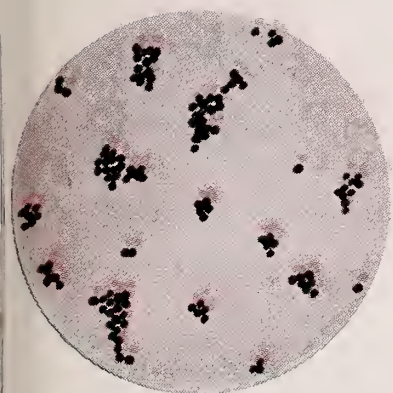
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ADVERTISING

All pharmaceutical advertising must be approved by the State Journal Advertising Bureau of the American Medical Association to be acceptable for publication. Other advertising copy may be accepted subject to the approval of the Editor and members of the Editorial Board. All copy or plates must reach the *Journal* office by 10th of the month preceding publication. General and classified advertising rates will be furnished on request.

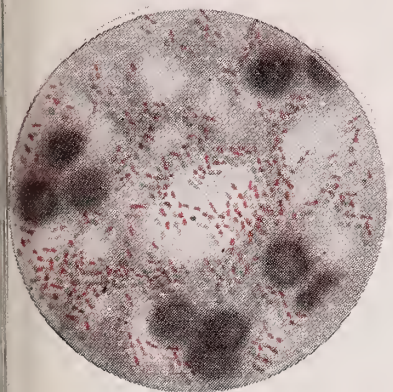
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If in the opinion of the *Journal* Editorial Board, material submitted for publication could be improved by a Medical Editing Service, the Editor will contact the author for his approval. Association members needing assistance in preparation of material for publication may also use this service. A reasonable charge is made for this service and the cost of this will be borne by the author.



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COVER—Our 1954 Journal covers are grouped together on this December Index Issue to form a Christmas greeting from the Journal staff to Georgia's physicians.

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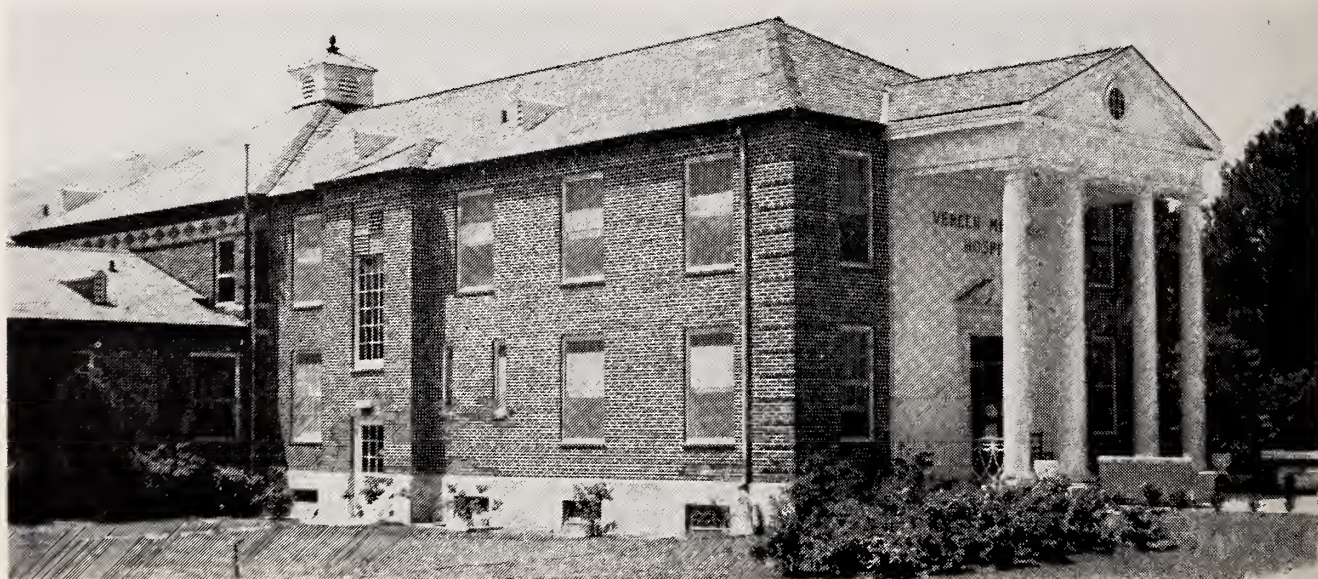
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The Newton County Hospital at Covington, Georgia, was opened for reception of patients on

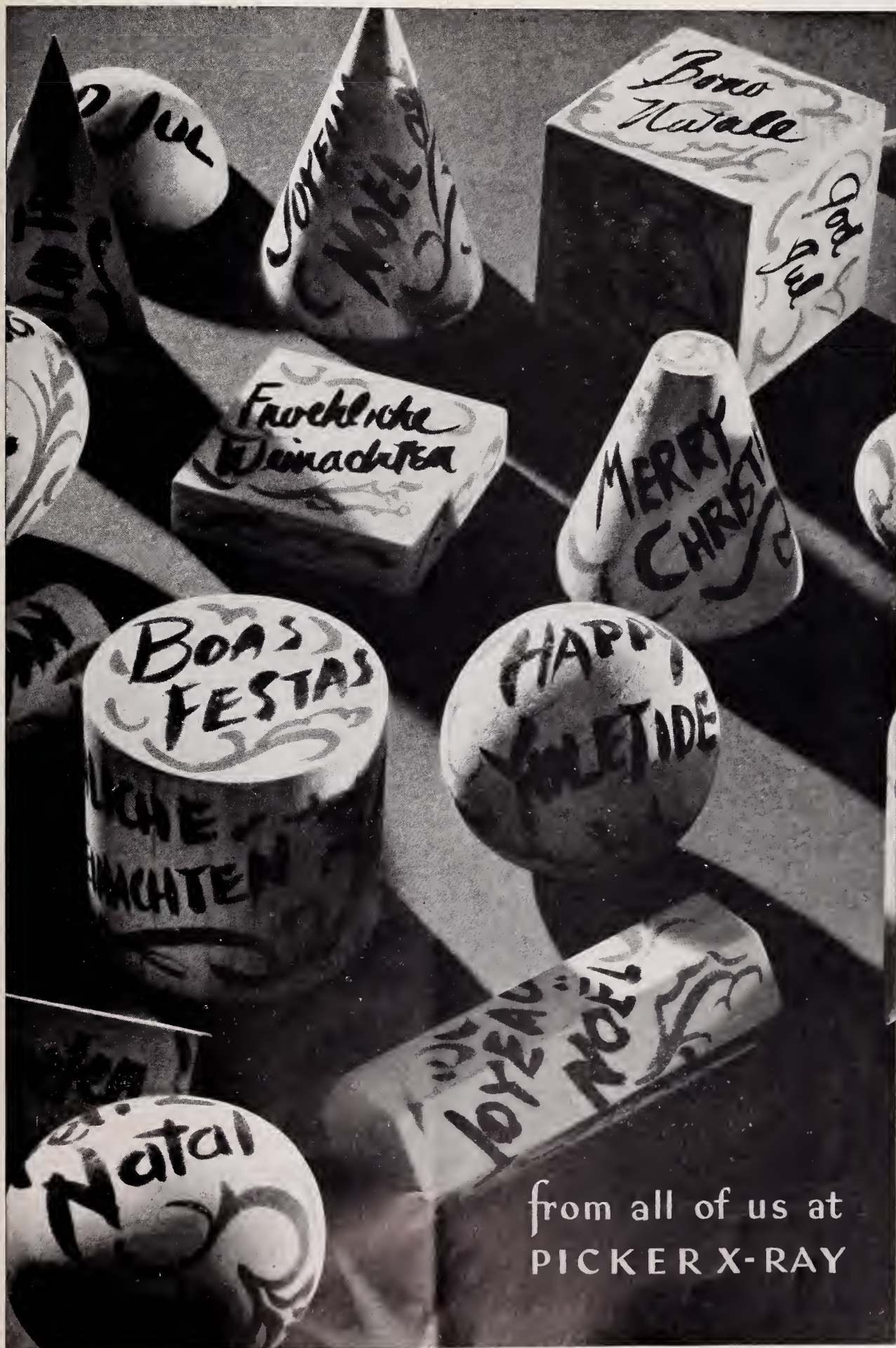
October 18, 1954. This 34 bed hospital was recently completed under the Hill-Burton Program.



VEREEN MEMORIAL HOSPITAL
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A recent enlargement of the Vereen Memorial Hospital, Moultrie, has added 24 beds, bringing the total number to 82 beds. Also included in the addition were an obstetrical suite, nursery, ad-

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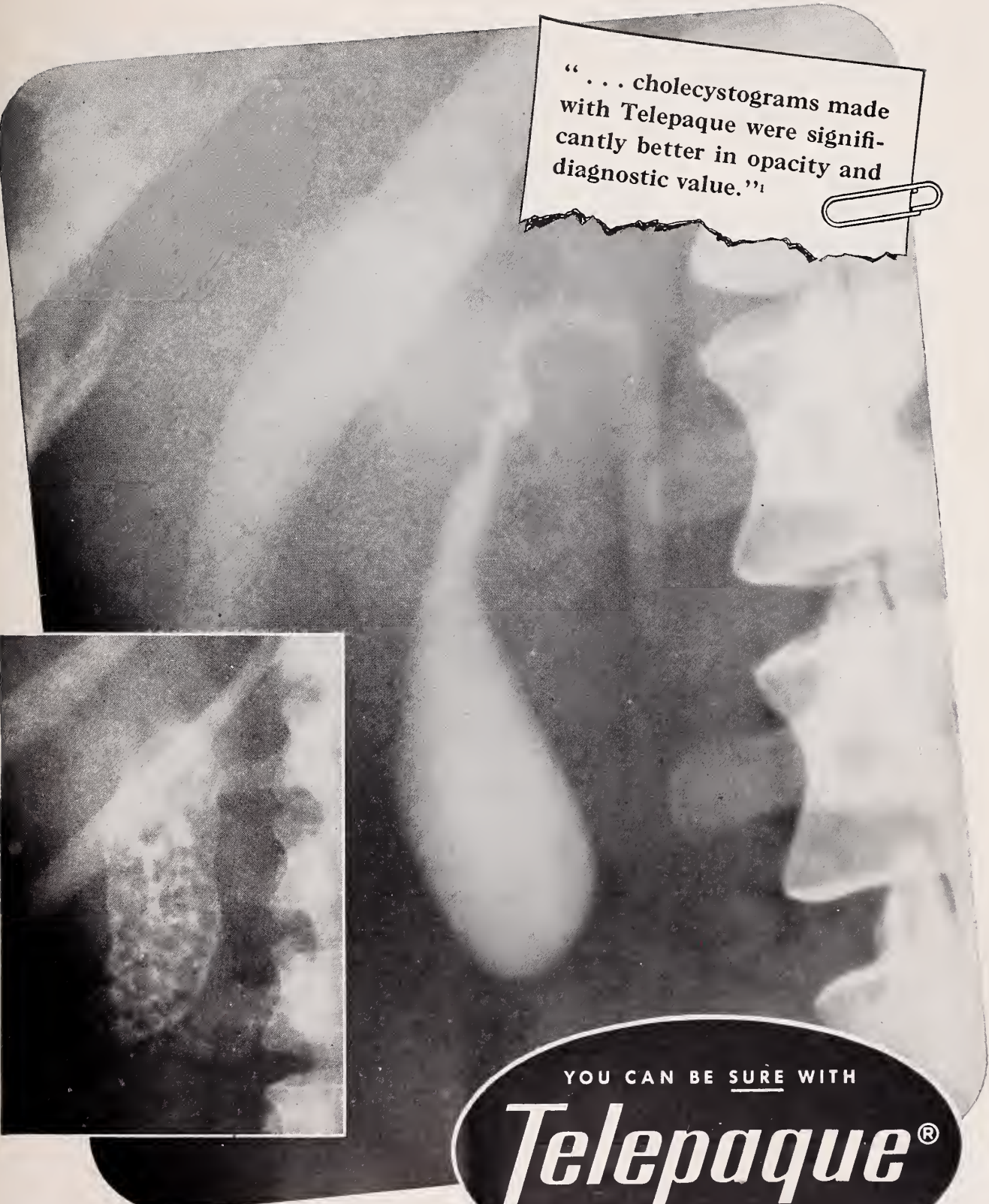


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¹ Abel, M.S., Lamhoff, I.L., and Garcia, C.V.: *Permanente Found. Med. Bull.*, 10:95, Aug., 1952.

² Lowman, R.M., and Stanley, H.W.: *Connecticut Med. Jour.*, 16:591, Aug., 1952

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Conference Headquarters — Municipal Auditorium — March 7-10, 1955

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DERMATOLOGY	MARCUS R. CARO, M.D., Chicago, Ill.
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GYNECOLOGY	WILLIS E. BROWN, M.D., Little Rock, Ark.
INTERNAL MEDICINE	TINSLEY R. HARRISON, M.D., Birmingham, Ala.
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NEUROSURGERY	LEONARD T. FURLOW, M.D., St. Louis, Mo.
OBSTETRICS	THADDEUS L. MONTGOMERY, M.D., Philadelphia, Pa.
OPHTHALMOLOGY	F. BRUCE FRALICK, M.D., Ann Arbor, Mich.
ORTHOPEDIC SURGERY	GEORGE J. GARCEAU, M.D., Indianapolis, Ind.
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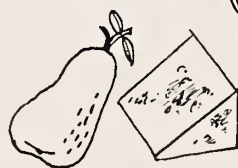
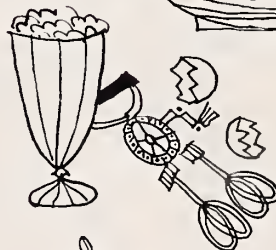
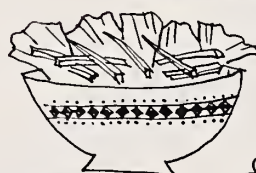
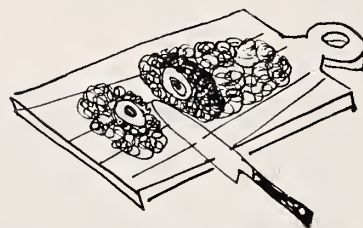
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References: 1. Hollander, F.: Arch. Int. Med. 93:107 (Jan.) 1954
2. Deutsch, E.: Scientific Exhibit, Gastroscopy, Clinical Meeting A.M.A., St. Louis, December, 1953



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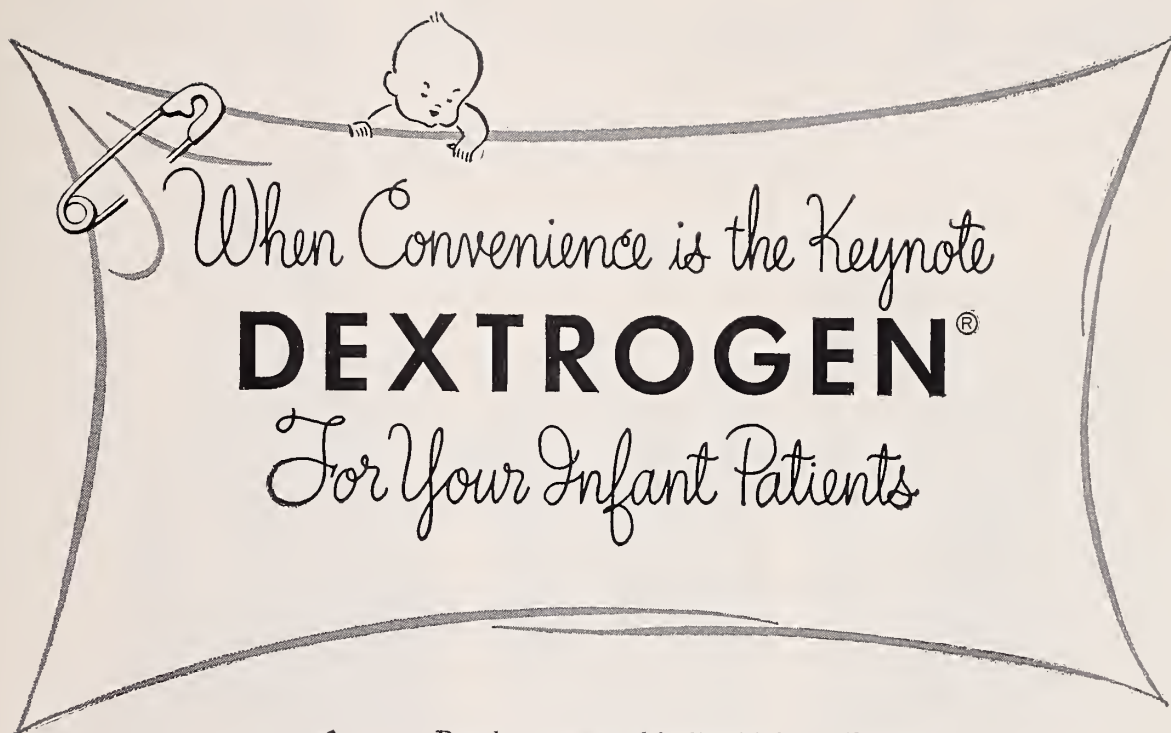
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MAG House of Delegates

For the first time in the history of the Association, the House of Delegates met in a special called session in Macon on December 12. The delegates from each of the component societies were sent material for their consideration, and each society met prior to the House of Delegates session to instruct their delegates. The principal matter considered at the special session was the proposed policies for the operation of the Eugene Talmadge Memorial hospital in Augusta.

The MAG Council, feeling that the policies of the Talmadge Hospital vitally concern every physician in Georgia, called this special session (see "The Association" section of this issue for "Minutes of the Council Meeting, Nov. 4, 1954."). Council wanted the profession as a whole to discuss these policies as presented by Medical College of Georgia President Edgar Pund.

Meeting concurrently with the House of Delegates on other MAG problems were the Insurance Board, the Honorary Advisory Board and the Public Relations Committee. The Delegates session was preceded by a recessed meeting of the Council. Minutes of these meetings will be published in an early issue of the Journal.

Public Health Committee

A preplanning meeting of the Public Health Committee was held recently (see "The Association" section of this issue for "Minutes of the Public Health Preplanning Meeting, October 27, 1954"). A re-organization of the structure of the committee was considered at the meeting. Realizing that some nine or 10 other MAG committees considered problems of public health, it was suggested that the Public Health Committee be made up of the chairmen of these other committees. This would then allow the Public Health Committee to function largely as a "screening body" to refer various problems and projects to the MAG committees concerned. It would further avoid duplication of work by committees and would correlate committee activity. These various committee chairmen will be asked to meet with the Public Health Committee on Sunday, January 9, 1955, at the Regional Health Auditorium, Macon.

Rural Health

The AMA Rural Health representative, Mr.

Aubry Gates, met with MAG Rural Health Committee Chairman George T. Nicholson in a preplanning session to discuss committee activity. Following this session, a meeting of the Rural Health Committee was held November 14 in Macon. With 100 per cent attendance, the committee discussed its 1954-55 program. The enthusiastic response from committeemen assured continued activity.

Scientific Exhibits

Available space for scientific exhibits at the MAG 105th Annual Session, Bon Air Hotel, Augusta, May 1-4, 1955, includes 19 booth spaces adjacent to the exhibit hall. Please write to Dr. Hoke Wammock, Medical College of Georgia, Augusta, for application blanks so that your exhibit may be accepted. With only 19 spaces available, your application should be made as soon as possible to insure adequate space. Dr. Wammock is MAG Awards Committee Chairman.

Society Minimum Standards

At the November 4 meeting of the MAG Council, a committee of Council was appointed to advise Council on the feasibility of certain minimum standards for county medical society organization. Faced with the problem of having some 25 to 30 component county societies at the present time inactive, the committee will attempt to set up minimum requisites for all societies. Suggested standards would ask that a society meet at least four times a year; approve a constitution and by-laws and a mediation or grievance committee; elect officers annually and maintain a permanent minutes book. This committee will report its recommendations at the next Council meeting.

AMA Delegates Report

Representing the Association at the AMA Clinical Meeting, Miami, Nov. 29-Dec. 2, 1954, were MAG Delegates Charles H. Richardson, Sr., Macon; Eustace A. Allen, Atlanta; and Spencer Kirkland, Atlanta. Also in attendance was Hartwell Joiner, Gainesville, who participated in a panel on Veterans Affairs. Other MAG Committee chairmen attending events scheduled for them were Rural Health Chairman George T. Nicholson and Public Relations Chairman Chris J. McLoughlin. The Headquarters Office was represented by Mr. Milton D. Krueger.



Officers and guests at the GAGP Sixth Annual Session, from left to right: J. B. Kay, Byron; Fred Simonton, Chickamauga; George H. Alexander, Forsyth; Peter Hydrick, College Park;

Maurice Arnold, Hawkinsville; Ben K. Looper, Canton; W. G. Elliott, Cuthbert; Harry L. Cheves, Union Point; and AAGP President W. B. Hildebrand, Menasha, Wisconsin.

Successful GAGP Session

One hundred and nine members of the Georgia Academy of General Practice recently met at their Sixth Annual Session, October 20-21, Atlanta. Over 60 guest physicians attended the two day meeting. The GAGP officers (see picture) elected

at the meeting were: George H. Alexander, Forsyth, *President*; W. G. Elliott, Cuthbert, *President-Elect*; Maurice F. Arnold, Hawkinsville, *Vice-President*; and Ben K. Looper, Canton, *Secretary-Treasurer*.

Milton D. Krueger
Executive Secretary

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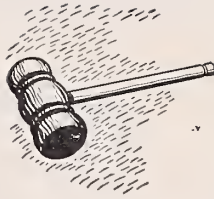
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president's page

It is a privilege and a real pleasure for me to have this opportunity of extending to all of the doctors of Georgia, and their families, a sincere wish for a Merry Christmas and a Happy New Year.

Our profession, through the graciousness of God, has progressed and prospered, therefore, may we ever be mindful of the administrations of the Great Physician and the spirit in which He worked.

"He came forth and saw a great multitude, and He had compassion on them and healed their sick." Grant that we acquire the ability to follow the example of physician-patient relationship exhibited by Him.

In commemoration of His birth, may we all have a joyous Christmas.



BOOKS RECEIVED

The Rauwolfia Story, Ciba Pharmaceutical Products, Inc., Summit, N. J., 1954, 63 pages.

Pulmonary Fibrosis in Soft Coal Miners, U. S. Government Printing Office, Washington, 1954, 59 pages.

Mobilizing Your Personnel Resources for Better Patient Care, Office of Defense Mobilization, Washington, 1954, 55 pages.

Uses of Wine in Medical Practice (A Summary), Wine Advisory Board, San Francisco, 1954, 42 pages.

Gillilan, L. A., Ph.D., M.D., *Clinical Aspects of the Autonomic Nervous System*, Little, Brown and Company, Boston, 1954, 316 pages, 42 illustrations, \$6.50.

Welch, Henry, Ph.D., *A Manual of Antibiotics*, 1954-1955, Medical Encyclopedia, Inc., New York, 1954, 87 pages, \$2.50.

Andrews, George Clinton, M.D., F.A.C.P., *Diseases of the Skin, for Practitioners and Students, Fourth Edition*, W. B. Saunders Company, Philadelphia and London, 1954, 877 pages, 777 illustrations, \$13.00.

Russell, Lord, of Liverpool, C.B.E., M.C., *The Scourge of the Swastika*, Philosophical Library, New York, 259 pages, \$4.50.

Yost, Orin Ross, M.D., *The Bane of Drug Addiction*, The Macmillan Company, New York, 1954, 155 pages, \$4.00.

Kilman, Ed and Wright, Theon, *Hugh Roy Cullen, A Story of American Opportunity*, Prentice-Hall, Inc., New York, 1954, 376 pages, \$4.00.

Campbell, Meredith, M.S., M.D., F.A.C.S., *Urology*, Volumes I, II and III, W. B. Saunders

Company, Philadelphia and London, 1954, 2,356 pages, 1,148 figures, \$60.00 per set.

Jawetz, Ernest, Ph.D., M.D.; Melnick, Joseph L., Ph.D.; and Adelberg, Edward A., Ph.D., *Review of Medical Microbiology*, Lange Medical Publications, Los Altos, Cal., 1954, 360 pages, \$4.50.

Rodale, J. I., *This Pace Is not Killing Us*, Rodale Books, Inc., Emmaus, Penna., 1954, 64 pages, \$1.00.

Shock, Nathan W., Ph.D., (Editor), *Problems of Aging (Fifteenth Conference)*, Josiah Macy, Jr. Foundation, New York, 1954, 213 pages, \$4.25.

Hoffbauer, F. W., M.D., (Editor), *Liver Injury (Twelfth Conference)*, Josiah Macy, Jr. Foundation, New York, 1954, 193 pages, 52 illustrations, \$4.25.

Stevenson, George S., M.D., *Administrative Medicine (Second Conference)*, Josiah Macy, Jr. Foundation, New York, 1954, 159 pages, 11 illustrations, \$3.00.

Reifenstein, Edward C., Jr., *Metabolic Interrelations with Special Reference to Calcium (Fifth Conference)*, Josiah Macy, Jr. Foundation, New York, 1954, 369 pages, 127 illustrations, \$5.00.

Senn, Milton J. E., M.D., *Problems of Infancy and Childhood (Seventh Conference)*, Josiah Macy, Jr. Foundation, New York, 1954, 168 pages, \$2.75.

Bradley, Stanley E., M.D., *Renal Function (Fifth Conference)*, Josiah Macy, Jr. Foundation, New York, 1954, 180 pages, 47 illustrations, \$3.75.

Green, Harold D., M.D., *Shock and Circulatory Homeostasis (Third Conference)*, Josiah Macy, Jr. Foundation, New York, 1954, 232 pages, 61 illustrations, \$3.50.

REVIEWS

THE CONCEPT OF SCHIZOPHRENIA, by W. F. McAuley, M.D., D.P.M., Philosophical Library, New York, 1954, 139 pages.

This publication is a brief review of the historical background and an evaluation of the present knowledge of schizophrenia based on a comprehensive inquiry into the bibliography and on the author's experience.

The divergent opinions in the interpretation of the facts obtained in the numerous studies described are presented. The author attempts to reconcile these and to establish their relative values in the theories of causation. The survey of modern treatment is limited to a very brief discussion of insulin shock and leucotomy. Neither the work of John Rosen and Frieda Fromm-Reichmann on psychotherapy in schizophrenia or the role of electroshock therapy is mentioned.

The author concludes that the schizophrenic mind is one that has not adapted itself to the social environment.

Since the author is English most of the bibliography is understandably from English sources.

The book, planned as a guide to students preparing for examinations in psychological medicine, is a useful review for this purpose. The chapter on diagnosis may be of special interest to the general physician.

Joseph S. Skobba, M.D.

MODERN CLINICAL PSYCHIATRY by Arthur P. Noyes, M.D., Norristown, Pennsylvania. 4th Edition—1953.

This textbook remains the classic work on the subject of modern clinical psychiatry. Following a brief and unapologetically teleological introduction, the first seven chapters are devoted to consideration of basic psychiatric concepts and principles and to examination of the patient; the next 15 chapters, to organic psychiatric diseases, including mental deficiency. The next 11 chapters deal with psychoses and psychoneuroses, including psychophysiologic disorders, with separate chapters for sociopathic personality disturbances and drug addiction. The final three chapters are entitled "Child Psychiatry," "Shock and other Physical Therapies," and "Psychotherapy." This 4th edition is entirely rewritten and enlarged by 100 pages and smaller print. Comparison of this with the preceding edition gives a striking reminder of the tremendous advances in psychiatry in the past few years.

The information contained within this volume is as authoritative as can be obtained, and it is presented with the most painstaking accuracy and completeness. "Completeness" should perhaps be qualified with reference to two portions of the book: (1) The section on organic psychiatric conditions is never complete in a psychiatric text and could not be unless the volume were ex-

panded to cover a considerable portion of the disciplines of neurology and internal medicine. (2) The section on psychotherapy is short and satisfies itself with descriptions of various systems, including group therapy; it consists of a synoptic survey of psychotherapy.

The "descriptive psychiatry" is excellent; psychobiological concepts are presented in far more detail than psychoanalytic psychodynamics. Therapy, other than psychotherapy, is described in detail. Otherwise, administration of psychiatric patients is only generally described, and no effort is made to elucidate the problem of administration of the patient being treated by psychotherapy. "Disposition" of the new psychiatric patient is not discussed as such.

Although the author is superintendent of a state hospital, the work is not limited to the viewpoint of the traditional state hospital psychiatrist; the vast experience of Dr. Noyes is evident. He is a teacher as well as administrator (Associate Professor of Psychiatry, Graduate School of Medicine, University of Pennsylvania), and is currently President of the American Psychiatric Association. Perhaps the most astounding aspect of this book is the refreshing lack of prejudice of the author, attesting to one form of greatness.

Readability is excellent as psychiatric texts go; examples cited are good. There is occasional ambiguity through lack of commas. Terminology peculiar to psychiatry is used without the provision of definitions and no glossary is provided; therefore, the uninitiated will need a dictionary and preferably a psychiatric dictionary at that. Provision of a glossary would increase the value of the book for medical students, interns, general practitioners and internists. As it stands it is probably most useful to the psychiatric resident—and is an excellent reference for the psychiatrist.

Richard E. Felder, M.D.

County Medical Public Relations Manual

The ABCs of medical public relations are neatly spelled out in AMA's new "County Medical Public Relations Manual." Prepared by the Department of Public Relations as a working manual for county medical societies, this booklet comprises the first comprehensive textbook on medical PR. The Manual explains how to organize for

PR action, outlining dozens of PR projects which local medical societies can conduct to win the respect and confidence of the community. State medical societies will receive a supply of Manuals about December 1 for distribution to county PR leaders.

The Need for Cancer Education Among Those of Lower Income Brackets

KIRK SHEPARD, M.D., Thomasville, Ga.

A GREAT DEAL of interest has been manifested in recent years in the use of cytological vaginal smears in the early detection of cancer of the cervix. Lester Harbin's report of more than 17,000 such examinations revealing more than 76 cases of carcinoma of the cervix gives an excellent idea of the potentialities of such study. Cases detected by this method before there is any visible or palpable evidence of cancer should conceivably have a survival rate of more than 85 per cent.

Unfortunately such ideal practice is still very far from that encountered in some of our clinics. Since January 1, 1951, 58 cases of carcinoma of the cervix have been seen for the first time at the Thomasville Tumor Clinic. These have been grouped as follows:

Stage I	Stage II	Stage III	Stage IV
25	8	11	11
or	or	or	or
43.1 %	13.8 %	18.9 %	18.9 %

Carcinoma in Situ—1 case.

Unclassified—2 cases.

In many instances these cases were probably graded down so that the figure of 43.1 per cent Stage I cases undoubtedly represents a more hopeful outlook than actually exists. The most distressing circumstance is the fact that almost 38 per cent of the cases had reached a Stage III or IV classification before arriving at a clinic for

treatment.

In a few instances cases had been treated for metrorrhagia without a pelvic examination's having been done. This deplorable practice, however, was the exception and not the rule. The large majority of these cases had not been seen by any physician prior to an examination that prompted the local physician's sending them directly to the clinic.

No unusual diagnostic acumen is necessary to detect these cases, but they cannot be detected until they present themselves at the doctor's office for examination.

Despite the strenuous efforts at cancer education there are large groups that are being missed. One of these is represented by the lower income bracket in the rural areas. Ignorance and superstition of all forms must be combatted. These people have not yet been taught the desirability or necessity of consulting medical opinion when obvious signs and symptoms of pathology make their appearance. This step must be accomplished before the value of routine examinations can be realized by them. Also the value of routine check-up by the family physician has not been sufficiently impressed upon these people to prompt their spending the necessary time and money for it. To have our cancer education program, as well as the attention of each physician, focused on this situation would help to solve it as a medical as well as a social and economic problem.

First Call for Scientific Exhibits
105th Annual Session, Augusta, May 1-4, 1955
see page 1030



Stimulating Interest in Heart Disease

MANUEL COOPER, M.D., Atlanta, Ga.

THE HEART PAGE is prepared by the Committee on Professional Education of the Georgia Heart Association. It is designed to present concise editorial summaries of the known facts on various topics in the diagnosis and treatment of heart disease. It is hoped that its audience will be comprised of those who have occasion to treat patients with heart disease, but whose primary work lies in more general fields. The articles appearing on this page are written with this in view.

A number of articles are now in preparation: "The Diagnosis and Treatment of Common Arrhythmias," "The Prophylaxis of Rheumatic Fever," "The Treatment of Acute Pulmonary Edema," "The Management of Uncomplicated Myocardial Infarction," "The Management of the Complications of Myocardial Infarction," "The Drug Treatment of Arterial Hypertension," "The Differential Diagnosis of Chest Pain," "Some Pitfalls in EKG Diagnosis," "The Selection of Patients for Cardiac Surgery," "Cardiac Neurosis," "Auscultation of the Heart" and "Early Recognition and Treatment of Occlusive Vascular Disease of the Extremities."

In addition, the Georgia Heart Association offers publications of a professional nature on the diagnosis and treatment of heart disease. All of these brochures are listed in a mimeographed catalogue available from the Georgia Heart Association; a few are mentioned to show the type of material available.

One of the most useful of these publications is a diet manual called *Food For Your Heart*. It is available at a cost of 25 cents per copy, and, as the sub-title states, is a manual for patients and physicians. It contains and explains low calorie and low sodium diets, and in addition it answers patients' questions on cholesterol and diet, the sodium content of foods, what to do when eating out and where salt-free commercial foods are available.

You and Your Heart is a complete pocket-sized book for 25 cents, written by five prominent cardiologists as a clinic for laymen on the heart and circulation. It is felt that any physician can read this book with profit. The enlightenment of

patients who have, and who think they have, heart disease is a major part of treatment, and this book reminds the physician of the patient's mind and attitudes. The chapter entitled "Misapprehensions (Some Common Fallacies About Heart Disease)" is especially worthwhile.

Much of the material available from the Georgia Heart Association is offered at no cost. There are two brochures on physical diagnosis in this category, *Examination of the Heart* and *Recommendations For Human Blood Pressure Determinations by Sphygmomanometers*. The latter is a six page report by the Committee of the American Heart Association to revise "Standardization of High Blood Pressure Readings." "This work contains many interesting observations on blood pressure measurement and explains in detail why the measurement of the diastolic pressure at the disappearance of sounds is recommended.

Other titles of general interest are: *How To Live With Heart Trouble*, *Returning Cardiacs To Work*, *Heart Disease in Children*, *Diagnosis of Congenital Cardiac Defects in General Practice*, *Heart Disease Caused by Coronary Arteriosclerosis*, *High Blood Pressure* and *Don't Worry About Your Heart*. A number of charts are available, including "Your Heart and How It Works" and "The Classification of Patients With Diseases of the Heart."

Every physician in Georgia should receive *Modern Concepts of Cardiovascular Disease*, published monthly by the American Heart Association. It contains summary information on recent developments in the field of cardiovascular disease and is distributed without charge by the Georgia Heart Association. Physicians who for some reason are not on the mailing list should correct this by writing the Georgia Heart Association, 318 Western Union Building, Atlanta 3, Georgia.

Speakers on any subject in cardiovascular disease are available for professional groups, and arrangements can be made through the Heart Association.

The Georgia Heart Association invites physicians to use its facilities.

Medicine and Citizenship

IN THE RECENT elections three of our fellow physicians were endorsed for seats in the State Legislature. Grady N. Coker early demonstrated his interest in good citizenship by serving as Mayor of Canton in 1928, an office in which he continued for seven terms. Since 1941, he has served three successful terms as State Senator from the Thirty-ninth District and now has been chosen Representative from Cherokee County to the General Assembly.

Marcus Mashburn, of Cumming, was similarly elected Mayor of his home town, serving in that capacity during 1919 and 1920. In 1929 he was chosen as Senator from the Fifty-first District. In 1949 he was returned as Representative from Forsyth County. He served capably as Senator from the Thirty-third District in 1951 and 1952. His return to the Legislature is regarded as an endorsement of his superior service to the people of his community.

Clarence L. Ayers of Toccoa was overwhelmingly elected to represent the Thirty-first Senatorial District of the State of Georgia for the next two years. Although this is his first venture into a State office, Dr. Ayers has been a leader in his community for many years. He served for 15 years as a member of the Toccoa School Board, is past president of the Toccoa Kiwanis Club and was named "Man of the Year" by the Toccoa Chamber of Commerce in 1949.

These three men have set an example for public service which we would all do well to emulate. The influence of physicians in public affairs has greatly diminished in the past hundred years. There was a time when we were civic leaders as well as professional men. To that position we must return. As physicians we have deservedly or undeservedly won the confidence of the common man perhaps more than have most other professional workers. The average man believes that we understand most of his problems and that we earnestly want to help him. Our counsel is sought for all sorts of perplexing problems in addition to those of illness. Such a relationship must bring infinite responsibility as well as infinite power.

Physicians' regard for human welfare traditionally transcends their political leanings. This in itself places us in a peculiarly advantageous position for public service. Because of the fact that we serve no political machines, our position for leadership is greatly strengthened. We can never hope to return to our position of influence in public affairs if we remain within the confines of our medical duties, pursuing blindly and furiously our limited objectives. We must of course fulfill our primary function of healing the sick, but we must raise our sights as well. Let each of us always remain "a citizen wherever we serve."



Clarence L. Ayers, M.D.



Marcus Mashburn, Sr., M.D.



Grady N. Coker, M.D.

Cranial Arteritis

MORE AND more cases of cranial arteritis are being reported. Head pain is the symptom which usually brings the patient to the doctor, although occasionally the presenting complaint is impairment of vision. It seems to be possible to relieve the head pain in several ways, including section of the vessel (and its nerve supply), procaine injection and administration of ACTH or cortisone. Not enough data are available to indicate whether loss of vision can be prevented or ameliorated by early treatment with steroids. Anticoagulants have not been used in enough cases to permit reliable conclusions regarding the possibility of their preventing the arteriolar occlusions which occur.

The fact does not seem to be widely appreciated that the arteritis may involve any of the larger

branches of the aorta, such as the subclavian, renal, carotid, coronary, brachial or femoral artery. Judging from the emphasis on relief of the head pain, one concludes that it is also not universally appreciated that this may be a widespread, chronic, often progressive, sometimes fatal, systemic disease.

Aside from the headache and visual symptoms, the clinical picture may suggest a collagen disease, because of the rheumatic pains, anemia and elevated sedimentation rate. Most pathologists agree that the process is not identical with periarteritis nodosa. Because the etiology is obscure, these cases should be referred whenever possible to medical centers, where they can be intensively studied in the hope of finding answers to the riddle.

Burn Therapy-- A Surgical Emergency

EARLY APPLICATION of well-established surgical principles will forestall many difficulties which have produced an atmosphere of general indifference in the treatment of surface burns in the human. The patient's progress, as a result of proper care, and the physician's ability to rehabilitate him quickly, may become the source of much gratification.

Experience with the care of burned patients, either in the acute or late phase, soon makes one cognizant of certain stumbling blocks to adequate therapy. Shock—with failure to combat it promptly—and over-sedation comprise early difficulties. The individual who is so severely burned as to require hospitalization is also in need of immediate fluid replacement. A delay of four to six hours in administering fluids may prove fatal in instances where an otherwise reasonable chance of salvage exists. This is particularly true in the

treatment of children who have been scalded by hot water or coffee, and in whom shock is the greatest deterrent to recovery. Proper care of the burn wound in such instances is usually short-termed and successful.

In Georgia, many burns occur in rural areas or small communities, hence the problem of transportation to a distant hospital or medical center frequently arises. Because the receiving physician can better treat the patient after personally evaluating the surface area involved and because immediate redressings are unsafe, none should be applied beforehand. Wrapping the patient in a sterile sheet, surgical gown, or towels or—lacking these—in a freshly laundered sheet, if he is to be moved any distance, will provide adequate initial protection. In transit, the patient should be given Hartmann's (Ringer's-Lactate) solution or five per

cent dextrose in normal saline intravenously. Dextrose in distilled water or other fluids should not be given subcutaneously for they may produce more profound shock or water intoxication. In a recently reported fatality, intravenous fluids were omitted and the patient was allowed to drink copious amounts of tap water en route to the hospital, only to die of water intoxication shortly after his arrival.

Every physician should be familiar with the appearance of third degree burns and the physical changes (ably described in surgical texts and journal publications) that accompany them. Prompt recognition leads to early debridement, followed shortly by covering the granulating areas with split thickness skin grafts to promote a less painful course of recovery and to prevent morbidity and many late sequelae. This course should be followed even in relatively small third degree burns affecting no more than eight to 10 per cent of the body surface—and particularly when the burn involves the flexion creases overlying joint areas.

Maximum adrenal response to stress exists in any severely burned patient. Well-documented studies demonstrate the dangers of the administra-

tion of ACTH and the very likely equivalent hazards accompanying the use of cortisone. Rarely, and then only in cases of proven adreno-cortical insufficiency, should cortisone be considered in the therapeutic regimen.

Psychological and physical imbalance are readily apparent in patients whose referral to the hospital comes after weeks of repeated dressings, soaks or re-applications of the many ointments described as beneficial. Early rehabilitation and the return to daily living activities, even during his hospitalization, are of paramount importance. In addition to surgical and metabolic treatment, physical therapy can hasten the program, and frequently it may be used even between staged grafting procedures.

The disruption of the severely burned patient's personal life is but one phase of the problem. Socio-economic factors are also involved. For this reason, physicians, teachers, social agencies, industrial safety engineers and others should accept a responsibility for instruction in the avoidance of accidents leading to third degree burns and in the reduction or elimination of environmental hazards.

Children Suffer Hospital Shock

A study of 124 hospitalized children, ages one to 11, has shown that one out of every five suffered emotional disturbances as a result of hospital experience which lasted longer than one month. The study was made by Dr. David Levy, pediatrician in Children's Hospital in Detroit.

From the child's standpoint, the situation in the hospital, Dr. Levy points out, is similar to battle, a dangerous place far from home with strange persons. The symptoms of the child are similar to the symptoms of an adult suffering from combat neurosis.

The hospital experiences which seem to arouse the most fear in children are anesthesia (use of gas to cause loss of consciousness), separation from parents, and jabs and punctures connected with hospital routine.

It can be readily understood that the small child might associate loss of consciousness in anesthesia with impending death. Unless properly pre-

pared by his parents a few days in advance of hospital entrance, this can be a terrifying experience to a child.

Psychiatrists recommended that the hospitalized child be told in simple terms what is going to happen to him. This knowledge will help him dispel much of the fear in facing the ordeal.

For the mental health of children, many child psychologists believe that parents should be allowed to spend more time with hospitalized children than is now possible in most such institutions. The parents' presence before an operation reassures the child of his safety. If they are allowed to be present when he wakes up, the feeling of fright is further minimized.

It has also been recommended by many students of this problem that ways be found to cut down on the number of jabs and punctures given hospitalized children wherever possible.

Cranial Arteritis

HAYWOOD N. HILL, M.D., Atlanta, Ga.

IN A TREATISE on "Diseases of the Arteries" published in the London Archives of Surgery in 1890, Hutchinson¹ described an unusual type of inflammation of the temporal arteries which caused severe headache. This description, however, was apparently overlooked or forgotten, and no further cases were described until 1932 when Horton, Magath and Brown,² at the Mayo Clinic, described two cases which were apparently identical with Hutchinson's, and which they called "Temporal Arteritis." Since that time there have been case reports from all over the world, and in 1948 Crosby and Wadsworth³ were able to collect and analyze 43 cases. Since 1948 every issue of the Quarterly Cumulative Index has listed at least one report; so the condition must not be as rare as the earlier writers believed. The chief reason for reporting a single case, however, is not merely that it is unusual, but that something specific can be done about it—which is not ordinarily true of the rarer diseases. The purpose of this paper is to describe a characteristic case, review the present knowledge of the disease in general and discuss a simple and practical approach to treatment.

CASE REPORT:

The patient was a 68-year-old, white widow, who was first seen on May 25, 1953, complaining of severe headache. She stated that this headache had begun some three months before. It was located at first primarily at the back of her head and was most severe when lying in bed, but she had also noted that turning her head would cause her ears to hurt and "pop." The headache became progressively worse, and she had consulted her physician about four weeks before. He felt that she had some local infection and gave her antibiotics without any real relief. Her neck and face had become slightly swollen and "bumps" had appeared on her face and temples. She had been running a slight fever and ached all over. Most of the pain had now localized in the temples, in front of the ears and in the jaws, which were difficult to open. There were no other significant symptoms, and the past history was generally non-contributory.

On physical examination it was noted that the patient was obviously miserable. She was 5 ft., 4½ in. tall, weighed 148

pounds, pulse was 88, blood pressure was 160/88 and temperature was 100.8° F. On the right temple, along the course of the artery, there was a bluish, elevated nodule, two cm. in diameter, which pulsated and was acutely tender. There was a smaller nodule just anterior to the ear on the left and a similar one anterior to the right ear. There was marked tenderness to pressure at the occipito-nuchal junction, but no nodule could be seen or felt here. Motion of the neck and jaws was normal. The optic fundi showed no well defined changes in the blood vessels, the ears were normal. She was edentulous. There was a Grade II rather harsh systolic murmur at the aortic area and along the left sternal border, but the murmur was not transmitted, and the heart was otherwise normal. The lungs and abdomen were normal. There was evidence of atrophic vaginitis and some external hemorrhoids. The left ankle was ankylosed due to an old injury, and there were some dilated veins around this ankle. Neurological examination was entirely negative.

Urinalysis was normal. The blood count showed a hemoglobin of 70 per cent with 3,740,000 red cells, and 10,050 white cells with a normal differential count. The erythrocyte sedimentation rate was 118 mm. in one hour (Wintrobe). The non-protein-nitrogen was 31. Her electrocardiogram was entirely normal. Chest roentgenogram revealed a heart at the upper limits of normal size but no other abnormality. X-rays of the skull were normal, and the cervical vertebrae appeared normal except for one prominent anterior osteophyte on C-VI.

It was felt that the patient had temporal arteritis; and, in an attempt to give her rapid relief, peri-arterial infiltration along both temporal arteries with two per cent procaine hydrochloride was performed on May 31. Relief of pain was immediate; and, although the numbness lasted only a few hours, there was definite and persistent decrease in the headache and tenderness. A second injection was performed two days later (June 2). On June 5, she reported increasing relief, and it was noted that the nodules were definitely smaller and less tender. The one in the temporal area had almost entirely disappeared, and only the ones in front of the ears were injected on this occasion. Her temperature was 99.8°. She was then started on oral cortisone acetate, 25 mgm. every six hours. On June 10 she was afebrile and there was only one small nodule remaining. This was injected again and the cortisone reduced to 25 mgm. every 12 hours. On June 15 the nodules were noted to have disappeared, and the patient complained only of mild pain and restlessness. On June 29 she still had some generalized aching and soreness but the local symptoms had subsided entirely. Cortisone was discontinued. Sedimentation rate on this date was 100 mm. per hour. (Wintrobe)

The patient then did well until the latter part of July when there was generalized aching in the back, neck and arms, and generalized weakness. This was treated with a high protein diet, protein supplements and massive doses of vitamin B-12, with satisfactory relief. Early in August there was a recurrence of one nodule, but it disappeared promptly with a short course of cortisone. On August 17, general physical examination revealed nothing of significance, and temperature was normal. Hemoglobin was 65 per cent; red cells, 3,500,000; white cells, 11,750. Sedimentation rate was 75 (Wintrobe). No new therapy was instituted.

During the winter the patient had no recurrence of local symptoms or signs, but she had much weakness, generalized aching, stiffness of the shoulders, knees and ankles and some edema around the ankles. It was felt that these were hypertrophic arthritic manifestations, and general supportive treatment was given. She did not really begin to feel normal until about March 1—the last time she was examined. She had at

Read before the Section on Internal Medicine at the 104th Annual Session of the Medical Association of Georgia, Macon, May 5, 1954.

that time some seborrheic dermatitis of the scalp and some edema around the ankles, but there was no evidence of recurrence of the arteritis. Her temperature was normal; pulse, 75; blood pressure, 135/100; and weight, 152 pounds. Hemoglobin was 81 per cent, with 4,220,000 red cells and 9,000 white cells. Sedimentation rate was 52. It was felt that she had recovered from her arteritis approximately one year after its onset, and she returned to the care of her local doctor.

This case seemed to me to fulfill all the criteria for the diagnosis of temporal arteritis as described in the literature. All of the reported cases, with one exception,¹ have been in individuals over 50 years of age, females predominating two to one over males. They have all been characterized by fever, anorexia, weakness, severe throbbing headache, pain in any or all of the structures around the head and neck, and tender, swollen, nodular, thrombosed temporal arteries. Generalized weakness, aching, arthralgia and weight loss have also been frequent. Mild anemia, leukocytosis and an increase in the sedimentation rate, ranging from slight to extreme, have likewise been constant findings. The duration has varied from eight weeks to 30 months, the average being around eight months. Recovery has been the rule.

It will be noted that this paper was entitled "Cranial Arteritis", whereas "Temporal Arteritis" has been referred to several times. This is because most of those who have studied this disease recently feel that it is a process involving any or all of the cranial arteries⁵ and that the temporal manifestations are merely the most obvious. Involvement of the retinal vessels has been described frequently, and blindness is not an uncommon complication.⁶ Fortunately, there was never any evidence of eye involvement in this case. The mechanism of the blindness in other cases is said to be thrombosis of the central retinal artery, or ischemic optic neuritis.

The cause of this condition is still entirely unknown. It has been thought to be part of a generalized periarteritis nodosa, but the clinical course is quite different. There is no eosinophilia, and the pathological picture³ shows definite differences. In cranial arteritis there is a granulomatous type of reaction with involvement of all the arterial coats, especially the media; areas of necrosis; a diffuse infiltration of lymphocytes, plasma cells, and some eosinophils and polymorphonuclears. Multinucleated giant cells are quite common. The lesion proceeds slowly to a necrosis of the media in small foci, with formation of granulation and scar tissue. There is extension of the inflammation to the intima with destruction of the endothelium, thrombus formation and probably some secondary phlebitis. These lesions are said to be quite charac-

teristic. Syphilis, thromboangitis and other diseases have been considered as the cause; but no clear proof of this relationship has ever been shown.

Soon after the condition began to be noticed, biopsies were performed to establish the diagnosis. It was observed that removal of the involved segment of the artery for biopsy was often followed by satisfactory relief of pain. This was the only method of treatment for some years and it remains a reasonably good one.

In 1948 Roberts and Askey⁷ deduced that the resection gave relief because of the interruption of periarterial sensory pain fibers, and that sympathetic periarterial block with procaine would produce the same result. They treated four cases in this way with very satisfactory relief, and their results have been duplicated by many others. Relief of pain may last for weeks or months. In 1950 Schlick, Baggenstoss, Fuller and Polley⁸ reported two cases treated with cortisone, without local therapy, with complete relief; and, likewise, their results have been widely duplicated.⁹

The French literature particularly is replete with reports of such therapy, using both cortisone and corticotropin, either of which seems to be quite efficacious.

It seems to the author that combination therapy is the most rational for most cases—periarterial infiltration for local relief of pain and hormonal therapy to control the general manifestations, and perhaps to arrest the progress of the disease in more vital but more inaccessible arteries. Of course removal of an involved segment remains an excellent treatment, especially when it is desired to prove the diagnosis as well. This case seemed to respond well to both approaches; and, although she undoubtedly had a systemic disease, which was not cured by either treatment, she certainly had marked relief and was much better able to tolerate the 12 long months of her illness. It will be interesting to note in the future whether cortisone arrests or prevents the progressive involvement of the retinal arteries—which seems to be the most dangerous manifestation of the disease.

The prognosis of the condition in general seems to be excellent, although it runs a protracted course. The mortality rate in the series reported by Crosby and Wadsworth³ was 12.5 per cent; but it must be remembered that these were elderly arteriosclerotic individuals and that death from intercurrent disease must be expected. Further-

more, death in many of the cases reported could not be specifically attributed to the cranial arteritis.

Cranial arteritis is a disease of the middle-aged and elderly, causing a great deal of pain and morbidity and is characterized by local and systemic symptoms and signs of unknown etiology, yet amenable to several useful methods of treatment. The diagnosis is simple and is only missed when it is not considered. The treatment can be carried out by any physician in his office. It would seem worthwhile then for every one of us to be on the lookout for it, because there certainly must be many cases seen by many doctors which never find their way into the literature. There is not a happier or more grateful patient than the one who has been relieved of disabling headaches, and there is no greater satisfaction for the physician than to be able to provide such relief.

478 Peachtree Street, N.E.

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New Report on Nutrition and Metabolism

A new report, believed to contain the most complete and authoritative numerical data on the subject of nutrition and metabolism ever assembled, has been published by the Air Research and Development Command's Wright Air Development Center.

The report, entitled "Standard Values in Nutrition and Metabolism," is the product of the contributions of more than 800 specialists both in this country and abroad. It is issued under the joint sponsorship of the Air Force, Navy, Army and the Atomic Energy Commission.

In its present form, it appears as Air Force Technical Report 52-301, though by this fall it will be available to the general public in a book published by the W. B. Saunders Company of Philadelphia, Pa.

The report is in the form of a handbook for use by laboratory and clinical investigators working on medical and biological problems associated with national defense. It is the second in a series, the first of which, "Standard Values in Blood," issued several years ago, already has won worldwide acclaim.

Taking advantage of the latest developments in the medical and biological sciences, this unusually comprehensive report contains thousands of figures, each checked and re-checked by the experts, listing the most recently authenticated nutritional requirements of living things. It presents hitherto unpublished diagrams illustrating the intricate pathways of foodstuffs as they are utilized by the body.

Included in the newer discoveries highlighted in this report is that metals such as zinc, vanadium and molybdenum, along with the better-known cobalt, manganese and copper, are required in the diets of certain types of organisms. It is pointed out, too, that bacteria, fungi and insects also must have their daily quota of vitamins.

Among the many outstanding features of this authoritative work is the first publication of new tables of basal metabolic rates. Prepared by the late Dr. Walter F. Boothby, of the Mayo Clinic, and Dr. Eugene F. DuBois, of the Cornell University Medical School, it is expected that these revised tables will form the new standards for clinical practice throughout the world.

Gangrenous Pneumatocele of the Greater Omentum Complicating Therapeutic Pneumoperitoneum

GEORGE T. NICHOLSON, M.D., Cornelia, Ga.

IN GEORGIA, where the use of therapeutic pneumoperitoneum is standard practice as a collapse measure in the treatment of pulmonary tuberculosis, the general practitioner and general surgeon are called upon more and more to render diagnoses of surgical conditions of the abdomen in the presence of pneumoperitoneum. Both elective and acute conditions are made more obscure due to the change of position of the abdominal viscera. This shift of position so alters the symptomatology that diagnosis is much more difficult.

The purpose of this report is twofold: (1) to report a case in which there was a rare condition arising from a rather common complication of therapeutic pneumoperitoneum as a collapse measure in the treatment of pulmonary tuberculosis, and (2) to illustrate the difficulty of diagnosis of surgical conditions of the abdomen in the presence of pneumoperitoneum, especially those of an acute nature.

As most of you are no doubt aware, in artificial pneumoperitoneum the diaphragm is forced upward from below and the abdominal viscera, including the liver, are pushed downward. The anterior abdominal wall is displaced outward by the inflation, and the small intestines are displaced toward the pelvis. This does several things to becloud the usual physical examination. Palpation of the viscera is almost impossible. Vaginal or rectal examination does not help much since the pelvis contains more than its quota of viscera.

We must therefore rely more heavily than ever on laboratory findings in the presence of pneumoperitoneum. Abdominal puncture as reported by C. M. Henry (J.M.A.G. Jan. 1951), a doubtful procedure at best, is of no value since one would most certainly obtain air and perhaps a small

amount of fluid. Unless there were gross infection with frank pus present, the tap could not be diagnostic, and in that case diagnosis could be made otherwise.

With the increased use of artificial pneumoperitoneum in the treatment of tuberculosis and the increased tuberculosis control program, more and more physicians in Georgia will be faced with the problem of diagnosis of surgical conditions of the abdomen, both acute and elective, in the presence of pneumoperitoneum.

CASE REPORT

Mrs. A. P., white female, age 22, was admitted to the hospital on March 30, 1953, the chief complaint being severe pain in the left upper quadrant of approximately 12 hours duration.

The present illness began on the evening of March 29, 1953, after the patient had retired. She stated that the onset of pain was sudden, extremely severe and occurred just after she had turned on her left side. A local physician was called and one-half grain of codeine was given, to be repeated every two to four hours. The pain was decreased by the opiate but was never completely relieved.

The past history revealed that the patient had never been a strong person. She had had many ailments including lobar pneumonia, a tumor of the breast, osteomyelitis, and a cesarean section Dec. 10, 1947. The cesarean section was done after the patient had been in labor for 48 hours and was found to have contracted pelvis; delivery per vaginam was impossible. The patient was in shock when she was admitted to the hospital for cesarean section. There were no fetal heart-sounds. Her postoperative course at that time was extremely stormy.

In November 1950 she was found to have pulmonary tuberculosis. Minimal Pneumoperitoneum was induced Feb. 17, 1951. Phrenemphraxis with total paralysis of the right diaphragm was done Feb. 26, 1951. During her sanatorium stay there was never any discomfort, and since her discharge there has never been any discomfort from the pneumoperitoneum. Her last refill of pneumoperitoneum was March 26, 1953, three days prior to the onset of the present illness.

X-rays made at the time of her admission showed what might be considered a pneumocele, but it lay in the area of the stomach and was assumed to be a large gas bubble in the stomach.

Physical examination revealed a well-developed and nourished white female, obviously acutely ill. The facies were drawn. Pulse was 110, but there was no dyspnea or cyanosis. The chest was normal for a patient with pneumoperitoneum, and both diaphragms were well elevated, with the right higher than the left. There was mild distention of the abdomen, but not more so than had been previously. There was moderate

tenderness over the entire abdomen, slightly more noticeable in the left upper quadrant. No muscular rigidity was apparent or, to say the least, detectable over the entire abdomen. Fleuroscopic examination revealed the gas bubble previously mentioned and a moderate amount of colonic gas. B.P. 90/60, pulse 110, temperature 98. The urinalysis was negative; Hb. 85 per cent; RBC 4,230,000; WBC 7,500 with a normal cell distribution.

A provisional diagnosis of partial intestinal obstruction was made and was considered to be due to the multiple abdominal adhesions apparent in the flat plate of the abdomen. The course for the next 30 hours was extremely erratic. At times the patient seemed improved, at other times it was doubtful. Approximately 30 hours after admission, the patient became much worse, and on April 1 the pain was so increased that an immediate exploratory laparotomy was considered advisable.

Operative Report

Under Cyclopropane anesthesia the abdomen was opened through a left trans-rectus incision, and the pneumoperitoneum was allowed to escape slowly through a small puncture wound. The escaping air had a sweetish, pungent odor. After releasing the pneumoperitoneum the incision was extended and a large, gangrenous pneumocele could be seen, apparently involving the left half of the greater omentum. The pressure of the pneumocele had partially obstructed the transverse colon. The pneumocele was then opened, and a large amount of air under pressure was released. The omentum was adherent to the anterior abdominal wall at the site of the old cesarean. The right half was not involved, but the left half was gangrenous and was removed to viable tissue. A node about one cm in diameter was found and removed for study. The lower half of the abdomen was a mass of adhesions, assumed to be due to the stormy cesarean section.

The pathologist reported only gangrenous and hemorrhagic

tissue. The post-operative course was completely uneventful. Her temperature remained normal during her hospital stay, and she left the hospital walking on her sixth post-operative day.

It is interesting to speculate on the mechanism of this peculiar phenomenon. Since it had been three days since her last refill, it is improbable that the refill was given into the omentum, but it is possible. It is also improbable that the air entered the greater omentum through the foramen of Winslow and dissected its way to the greater omentum because of the many dense adhesions. The most likely conclusion is that there was a rent in the omentum which became valvelike, and thus there was an ever increasing air pressure in the pneumocele.

Summary

A case of a gangrenous pneumocele of the greater omentum has been presented which demonstrates, (1) the difficulty of diagnosis of surgical conditions of the abdomen, especially those of an acute nature, in the presence of artificial pneumoperitoneum; (2) though small pneumoceles of the scrotum and through diaphragmatic hiatus hernias have been reported, there is no literature available on a pneumocele of the greater omentum, and no cases of gangrenous pneumocele are on record. The patient has recovered completely, but, needless to say, artificial pneumoperitoneum has been permanently discontinued.

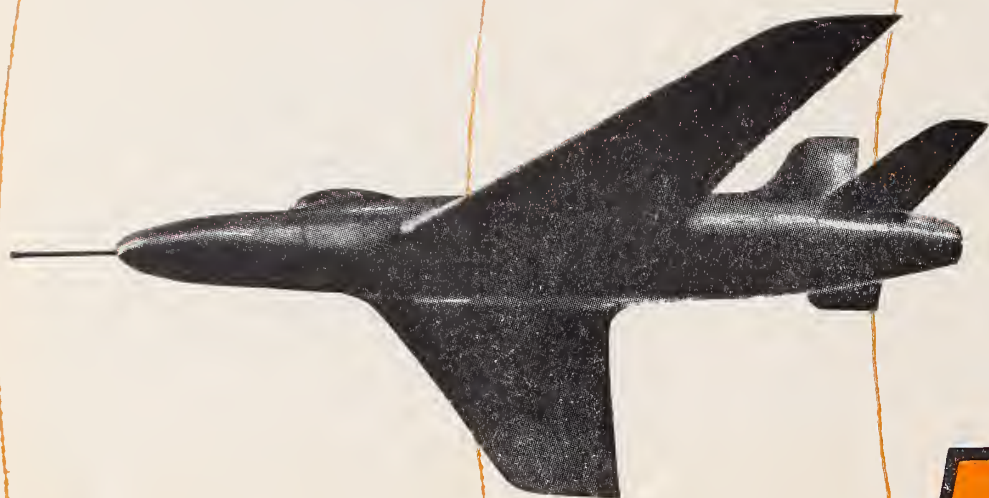
1955 American Medical Directory

The new, 19th Edition of the *American Medical Directory* is now in galley form, and it is expected that the book will be ready for delivery about the middle of 1955. The previous edition was issued in 1950. Since that time, it has not been possible to publish a new edition because changes in the membership structure of the American Medical Association made it difficult to obtain an accurate list of members.

Within the next few weeks, a directory information card will have been mailed to every physician in the United States, its dependencies and Canada, requesting information to be used in compiling the new Directory. Physicians receiving an information card should fill it out and return it promptly regardless of whether any change has occurred in any of the points on which information is requested. It is urged that physicians also fill out the right half of the card, which section requests information to be used exclusively for statistical

purposes. Even if a physician has sent in similar information recently, he should mail the card promptly to the Directory Department of the American Medical Association to insure an accurate listing of his name and address. There is no charge for publishing the data, nor are physicians obligated in any way.

The Directory is one of the most important contributions of the American Medical Association to the work of the medical profession in the United States. In it, as in no other published directory, one may find dependable data concerning physicians, hospitals, medical organizations, and activities. It provides full information on medical schools, specialization in the fields of medical practice, memberships in special medical societies, tabulation of medical journals and libraries, and statistics on the distribution of physicians and hospitals in the United States.



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The Eyes as a Cause of Headaches

WILLIAM O. WHITE, M.D., Augusta, Ga.

MORE PATIENTS consult the doctor because of headaches than any other single complaint. It has been variously estimated that from 15 to 25 per cent of all patients seen by physicians give headaches as their chief complaint. There is probably more medicine sold for headaches than for any other condition. Millions of pounds of aspirin are sold yearly. The diagnosis and treatment of headaches invade all medical and surgical specialties and have provoked the use of nearly every diagnostic and therapeutic tool known to man. Oliver Wendell Holmes once said, "If I wish to show a student the difficulties of medical practice, I should give him a headache to treat."

The practitioner when faced with a patient complaining of headache must determine, if he can, whether the headache is an ocular one or not. Certain types of headaches can be said to be not ocular in origin. Severe headache setting in rapidly in persons unaccustomed to headache is not ocular, and those associated with prostration and vomiting are not the result of eyestrain. It is the purpose of this paper to give a few of the criteria by which he may suspect that the etiology of the headache is of ocular origin.

The first consideration is that of taking a careful history of the patient. Heredity plays a large part in headache sufferers. In the migraine type headache, either one or the other parent has usually suffered from sick headaches. One observer has noted that over 60 per cent of patients with headaches gave a history of one or the other of their parents having had headaches. The age of the patient is important. There are very few children below school age who complain of headaches as a result of eyestrain. In children of school age and adolescence, there is always the possibility that headaches form a possible basis for

escape from school work and in older individuals that such complaints are based on some form of neurosis. Adults who are in the age of presbyopia complain of ocular discomfort, but rarely of genuine headaches; their eyes tire easily and print becomes blurred.

The onset and course of the headache often give very important clues. The examiner is frequently able to determine whether the headache is due to eyestrain or whether other factors are involved. The typical eyestrain headache comes on after the eyes have been used. It usually appears some hours after their use and gradually increases in severity if continued efforts are made to go on with the work at hand. When the headaches are spaced so far apart that it seems unlikely that the eyes are responsible, inquiry should be made regarding other possible factors. Patients with ocular neurosis are frequently spotted. They usually have good visual acuity and describe such unlikely situations as inability to even glance at print without the immediate onset of severe pain in the eye. Gunbarrel or tubular vision is frequently complained of by these patients. Another complaint often heard is inability to go from dark to light without having excruciating eye pains. Their description of the severity and continuity and bizarre features of the headache is usually sufficient to indicate their psychopathic state.

The next consideration is the location of the pain. Usually an ocular headache is frontal or orbital, more rarely is it occipital or temporal, and almost never is it vertical. It may be either bilateral or unilateral.

Bilateral pain, whether frontal, vertex, bitemporal, occipital, suboccipital or over the tip of the mastoid process, may be ocular in origin. It may be mild or as severe as that caused by a cerebellar tumor, and the patient must be examined by someone who will take the time to do other than hand him a pair of glasses. A pair of glasses is not a diagnosis, nor is it always the answer to the

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Dr. White is Associate Professor of Ophthalmology of the Medical College of Georgia.

problem of headache. Until one can safely say that the refractive error is the cause of the difficulty, the patient is entitled to a thorough study of the muscle balance, a visual field examination and one or more tension readings as may be required. The better the examination, the more frequently will the right diagnosis be made.

Unilateral pain may be caused by a spasm of the ciliary muscle, spasm of a single ocular muscle, localized neuralgia, inflammation of the gasserian ganglion or irritation of an internal carotid artery by an aneurysm. When ocular pathology is present, headaches are more likely to be unilateral. Such headaches are commonly encountered in acute glaucoma, in chronic glaucoma when the tension rises rapidly, and in iritis. It may or may not occur in retrobulbar neuritis, orbital cellulitis, photophthalmia, ptosis and extra ocular muscle paralysis. The retinoblastoma of children and the choroidal sarcoma of adults progress to glaucoma or to intracranial metastasis and thereby frequently cause headaches.

Next, the time of the onset of the pain should be considered. Commonly with ocular headaches the pain comes on in the late afternoon or early evening, that is, at the end of the day's work. Sometimes there is a delayed headache which the patient has on arising in the morning and is usually due to misuse of the eyes on the previous day. Another example of delayed headache is the week-end headache; the patient may be free from headache during the week, but on Sunday, although using his eyes less, he gets a headache.

Although the pain of eye headache may radiate through any of the branches of the trigeminal nerve, the initial cause is contracture of muscle. The muscles concerned may be the ciliary muscles, the extrinsic eye muscles or the occipito frontalis.

The simplest case of pain from ciliary muscle contracture is that of hypermetropia or farsightedness. Such a person can see clearly only by contracting the ciliary muscles, and throughout his working day they are in a state of tonic contraction, the contraction being greater when close work is done. After prolonged close work these muscles tire, and the patient finds his sight varying. He may seek relief by stopping his close work and gazing into the distance for some minutes, then he finds that he may return to his close work for a while longer. In the case of children, a farsighted child will often hold a book very close to his face in reading and will thereby put further

strain on the ciliary muscles in order to get a larger retinal image. However, in spite of this, he will seldom complain of headaches even though there is a tremendous increase in his accommodative effort.

Headaches due to extrinsic eye muscle abnormalities can often-times be eliminated by the use of prisms. This correction is in the domain of the ophthalmologist, but it should be mentioned that if attacks of diplopia occur, this condition should be suspected.

Many patients suffering from the occipital type of ocular headache partly close their lids together in order to get better vision. The frontalis muscles are inserted into the upper eyelids, and on contraction pull on the epicranial fascia, which in turn causes a pull on the occipital muscles, causing headache. The occipital headache of eye strain, however, seems clearly to be localized to the occipital muscles, and to be relieved by pressing on them. It is a form of headache which is easily relieved by wearing suitable glasses.

When an error of refraction is much greater in one eye than in the other, the headache may be more severe on the side of greater error or may be confined to that side. Sometimes the headache is superficial with cutaneous hyperesthesia, or again it may be deep and boring, full and throbbing, dull and heavy or sharp and piercing. The severity extends from the merely annoying to the completely incapacitating.

Ocular headaches occur more frequently in debilitated or run-down persons, or in those who have a neuropathic disposition. They are common after any lingering illness. It is not uncommon for a young woman previously free from headaches due to refractive error to acquire them during the last few months of pregnancy. Often the glasses which previously have been worn only part time before pregnancy must be worn constantly during the later months of pregnancy as well as a few months afterwards. Migraine headaches, with their preliminary scintillating scotomas, is not caused by the eyes, but in an occasional patient an uncorrected refractive error may be the trigger that starts the headache.

Summary

Several criteria are listed by which a headache can be suspected of being ocular in origin. A careful history of the headaches including consideration of such factors as heredity, age, onset and course is of great value. Bilateral headaches are

more likely to occur when both eyes are involved, and unilateral pain results when only one eye is involved or when the causative factor is greater in one eye than the other. Ocular pathology is found more often in the unilateral headache. The typical headache due to an error of refraction comes on in the afternoon and increases in severity the more the eyes are used for close work. It is relieved by suitable glasses. Other factors which play a part in causing the ocular type headache are the patient's general physical condition's

being in a state of debilitation, the patient's neuro-pathic disposition, lingering illnesses, pregnancy and migraine.

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Influence of Compounds Clinically Effective in Treatment of Premenstrual Tension on Electrolyte Excretion and Urinary Output of the Male Albino Rat

LOUISE WORTMAN BERMAN, M.A., and ROBERT B. GREENBLATT, M.D., Augusta, Ga.

ACCOMPANYING premenstrual tension there is usually weight gain, breast turgidity, abdominal bloating and edema. It has been suggested that the symptomatology of nervousness and apprehension associated with premenstrual edema is due to the retention of water and electrolytes for the four to seven days preceding the menstrual flow. Inasmuch as a number of drugs have been used successfully in the clinical management of such women,^{1 2 3} it was decided to study the possible mechanisms involved.

In recent clinical trials, the following preparations have been used to good advantage in treatment of women with premenstrual tension syndrome:

NEO-BROMTH® (2-amino-2-methyl-1-propanol 8 bromotheophyllinate + pyrillamine maleate.)

PRE-MENS® (ammonium chloride, homatropine methylbromide, caffeine alkaloid, thiamine hydrochloride, riboflavin, pyridoxine hydrochloride, calcium pantothenate, niacinamide)

SERPASIL® (reserpine—extract of *Rauwolfia serpentina*)

It was decided to undertake a study of the effect of these preparations on the urinary output and excretion of electrolytes in the rat. At the conclusion of the group of experiments utilizing Neo-Bromth, a study was made of the adrenal glands of the animals to determine whether the water

balance and electrolyte changes reported here were manifest through this organ.

Methods

The general procedure used for the study of the effect of Neo-Bromth, Pre-Mens and Serpasil on the excretion of water, sodium, potassium and chloride was as follows:

Eight Sprague-Dawley male albino rats, weighing from 250-300 grams at the beginning of experimentation, were used in the testing of each drug. Four animals were given the drug, and four animals served as controls in each group of experiments.

The rats were placed in separate metabolism cages on Monday morning, without food or drink, and given varying doses of the drug to be tested in 10 cc. of water by stomach tube. The controls received 10 cc. of water by stomach tube at the same time. Daily records of weights of the animals were made directly before stomach tubing. Four hours later the animals were given a recorded amount of sodium deficient diet and 50 cc. of water to drink, ad libitum. The daily intake of food and water was measured and recorded. Twenty-four hour urine specimens were collected, measured and analyzed for sodium, potassium and chloride. This procedure was repeated on the Tuesday and Wednesday of each week for a total of four weeks in the case of Neo-Bromth and Serpasil, and five weeks in the case of Pre-Mens. On the Thursday of each experimental week, the animals were taken off the sodium deficient diet and given regular laboratory chow and water, ad libitum, until the following Monday.

Several dose levels of each drug were used in the screening process. In each instance the first

From the Department of Endocrinology, Medical College of Georgia, Augusta, Ga.

Supplies of the medications used in this study are gratefully acknowledged:

NEO-BROMTH®—Brayten Pharmaceutical Company, Chattanooga, Tenn.

PRE-MENS®—Purdue-Frederick Company, New York, N. Y.

SERPASIL®—Ciba Pharmaceutical Products, Inc., Summit, N. J.

dose level of the drug used was equivalent to the clinical human dosage on a kilogram to kilogram basis. To test Neo-Bromth, the experimental animals received 160 milligrams per kilogram per day during the first two weeks of experimentation. During the second two weeks, the dose of Neo-Bromth was doubled to see if an increase in the quantity of the drug would effect the electrolyte excretion from a quantitative standpoint.

In the study of Serpasil, the four test animals received 12y of Serpasil per kilogram per day during the first week of experimentation. During the second, third and fourth weeks of the experiment, the eight rats were divided into four groups of two animals each. The first group served as the controls, receiving 10 cc. of water. The second, third and fourth groups received 25y, 50y, and 100y per kilogram per day of Serpasil, respectively.

To test Pre-Mens, the experimental animals received 500 milligrams of the powdered mixture per kilogram per day during the first three weeks and 1000 milligrams per kilogram per day during the last two weeks of the experiment.

As Neo-Bromth was the first of the three drugs tested, a number of studies were made which were not repeated in the work with Serpasil and Pre-Mens. During the first week of experimentation with Neo-Bromth, the animals were given one per cent saline in their drinking water to compensate for the lack of sodium in the diet. It was observed that the animals given Neo-Bromth consumed a significantly greater amount of water. To see if this were due to a greater need for salt, the

animals were given tap water to drink during the following three weeks. The elimination of sodium chloride from the drinking water did not decrease the consumption of liquid by the test group. As it was felt that the lack of sodium during the three experimental days each week would not be detrimental to the animals, tap water was used in the subsequent work with Serpasil and Pre-Mens.

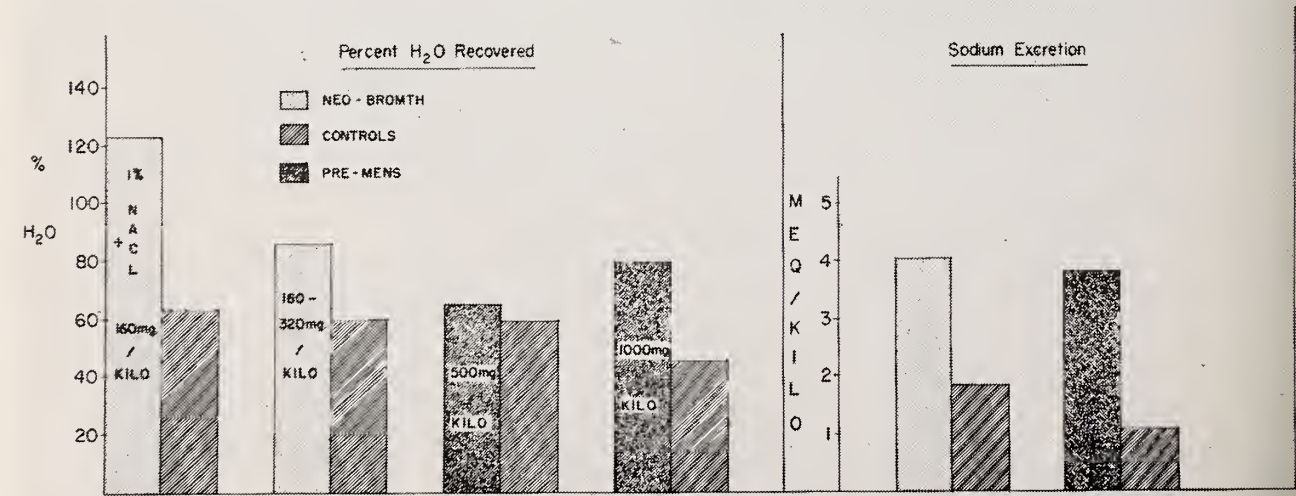
At the end of the four week study period of Neo-Bromth, the animals were killed by ether. The adrenals were removed by clean dissection, weighed on a torsion balance, and analyzed for cholesterol⁴ and ascorbic acid.⁵ The results obtained did not warrant a similar study in the cases of Serpasil and Pre-Mens. The cholesterol values are expressed in milligrams of cholesterol per 100 milligrams of tissue. The ascorbic acid results are expressed in milligrams of ascorbic acid per 100 grams of tissue.

Sodium and potassium determinations were made on the Beckman DU Flame Photometer.⁶ Chloride analysis was by the method of Schales and Schales.⁷ All electrolyte values are reported as milli-equivalents per kilogram with the standard error of the mean given. Differences in values between the experimental and control animals were considered significant only if $p < .02$.

Results

Some of the significant findings follow:

Serpasil: Serpasil, at the dose levels given has no significant effect on the urinary output or excretion of sodium, potassium and chloride. However, our own clinical observations have shown



Graph 1—Effect of Neo-Bromth® and Pre-Mens® on Excretion of Water and Sodium. In each case, the average of the values obtained with four test and four experimental rats during the weeks of experimentation are shown. Both drugs caused and

increased excretion of water and sodium. Doubling the dose of Pre-Mens quantitatively increased the excretion of water, but did not further increase the excretion of sodium. Doubling the dose of Neo-Bromth® had no such effect.

Serpasil to be an antidiuretic. Gaunt et. al.⁸ have reported similar findings in rats when treated with larger doses of the drug than used in these experiments.

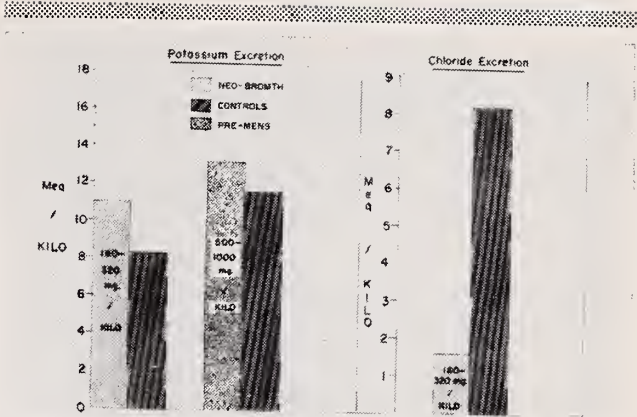
Neo-Bromth and Pre-Mens: Although Neo-Bromth was administered at two different dose levels, it was observed that an increase in the dosage did not effect the excretion of water or electrolytes, and for the purposes of this paper the results obtained in both instances have been pooled.

Water Excretion (See Graph 1). The excretion of water is expressed in terms of per cent water recovered to account for the greater intake of water by the animals receiving Neo-Bromth or Pre-Mens. The administration of Neo-Bromth significantly increased the per cent of water recovered during the weeks of experimentation. The greatest increase is seen during the week when the animals received one per cent NaCl in their drinking water. Pre-Mens likewise significantly increased the excretion of water. In addition, it can be noted that doubling the dose of Pre-Mens during the fourth and fifth experimental weeks increased the per cent water recovered over that of the controls from 12 per cent to 28 per cent.

Sodium Excretion: Neo-Bromth and Pre-Mens caused a significant increase in the excretion of sodium. It was noted during the course of these experiments that on the first experimental day of each week the excretion of sodium by both the experimental and control animals was much higher than on the second and third days of collection, due to the greater intake of sodium by the animals prior to the first day of collection each week. Increasing the dosage of either Neo-Bromth or Pre-Mens did not effect the excretion of sodium by the experimental animals from a quantitative standpoint.

Potassium Excretion (See Graph II). As significant increase in the excretion of potassium occurred due to the administration of Neo-Bromth. Pre-Mens, however, had no effect on the excretion of this electrolyte at either dose level.

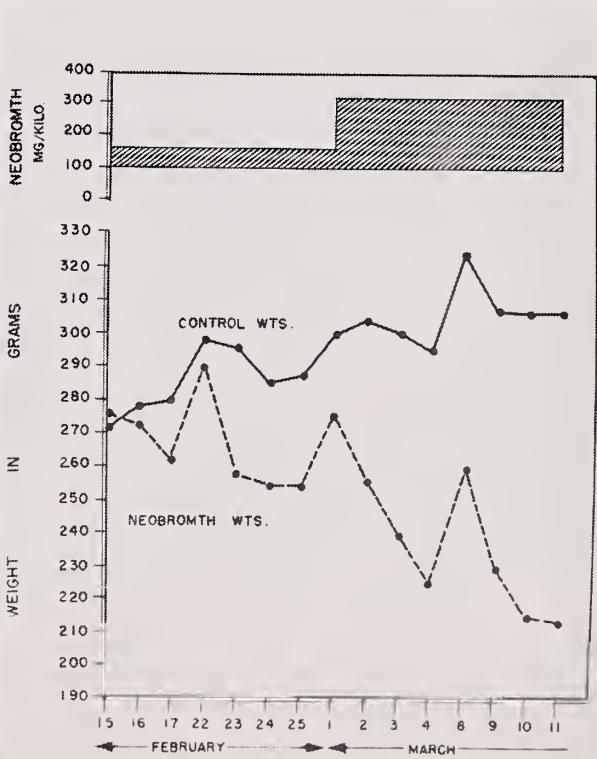
Chloride Excretion (See Graph II). Neo-Bromth caused a significant decrease in the excretion of chloride on the third experimental day of each week. A tendency toward decreasing excretion of this electrolyte on the part of the test group was observed on the first and second experimental days of the week, but this difference was not found to be statistically significant until the third ex-



Graph II—Effect of Neo-Bromth® and Pre-Mens® on Potassium and Chloride Excretion. In each case, the average of the values obtained with four test and four experimental rats during the weeks of experimentation are shown. Increased excretion of potassium occurred after administration of both dose levels of Neo-Bromth®, but not after the administration of either 500 or 1000 mg./kilo of Pre-Mens®. Neo-Bromth® caused a decreased excretion of chloride on the third experimental day of each week.

perimental day. The chloride output during treatment with Pre-Mens® was too variable to justify interpretation.

Weight Changes: Graph III shows the average weight curves of the Neo-Bromth treated and control rats during the four weeks of experimentation.



Graph III—Weight Loss Due to the Administration of Neo-Bromth®. Dots shown represent the average daily weight of the four experimental or four control rats.

TABLE I

CHOLESTEROL AND ASCORBIC ACID LEVEL, AND ADRENAL WEIGHT CHANGES DUE TO NEO-BROMTH®

	Experimental	p > .02		Control
Cholesterol (mg./100 mg.)	931 ±	93	608 ±	83
Ascorbic Acid (mg./100 gms.)	179 ±	16	176 ±	15
Weight (mg./kilogram)	*102 ±	11	66±	2

* p < .01

Observation of the weight curves and statistical analysis of the weight changes occurring during this time show that Neo-Bromth causes a striking and significant loss of weight. Pre-Mens, unlike Neo-Bromth, did not cause any loss of weight on the part of the treated animals. In addition, the average weight gain by the experimental animals during the period of study did not differ significantly from that of the controls.

Adrenal Changes: No significant differences were observed between the adrenal cholesterol or adrenal ascorbic acid levels of the Neo-Bromth treated and control animals. However, the weights of the adrenal glands on a per kilogram basis were significantly higher in the treated group (see table I). These results are indicative of possible adrenal stimulation by Neo-Bromth similar to that of mild prolonged stress. Under such conditions there is an initial depletion of the ascorbic acid and cholesterol levels, followed by their return to normal and accompanied by a hypertrophy of the gland. If the action of Neo-Bromth were through the stimulation of the adrenal cortex, one would expect to find a decreased excretion of water and sodium and an increased excretion of potassium. However, we have found that Neo-Bromth increases the excretion of water and sodium, as well as of potassium. Only this last action would be indicative of adrenal stimulation. Therefore, preliminary evidence seems to indicate that the effect of Neo-Bromth on water and electrolyte excretion is independent of the adrenal cortex.

Summary

Studies were made of the effect of Neo-Bromth®, Serpasil® and Pre-Mens® on the urinary output and electrolyte excretion of the male albino rat. Neo-Bromth increased the excretion of water,

sodium and potassium, but decreased the output of chloride. Serpasil, at the dose levels given, had no effect on either the urinary output or excretion of electrolytes. Water and sodium excretion increased under the influence of Pre-Mens, while the potassium output remained unaltered. The effect of Pre-Mens on the chloride excretion was inconsistent. Hypertrophy of the adrenal glands was observed in the animals treated with Neo-Bromth, but the drug had no effect on the adrenal cholesterol and ascorbic acid levels. These results indicate that the electrolyte and water balance changes incurred by Neo-Bromth are independent of the adrenal cortex. A striking loss of weight occurred with Neo-Bromth but not following Serpasil or Pre-Mens.

If the experimental findings may be equated with the clinical results obtained with Neo-Bromth, Serpasil and Pre-Mens in the treatment of premenstrual tension syndrome, it may be that Neo-Bromth causes weight loss with increased excretion of water and sodium, while the effectiveness of Serpasil is probably due to some central or cerebral action, i. e. one of tranquilizing the patient, while Pre-Mens, a mixture of a diuretic agent, an anticholinergic agent, a stimulant and vitamin B complex, probably acts in a variety of ways.

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Torsion of the Legs in Small Children

J. HIRAM KITE, M.D., Atlanta, Ga.

TORSION OF THE lower extremities in small children usually produces one of two types of deformities. We may call one "medial torsion of the legs," in which case the child will be pigeon-toed and somewhat bow-legged. We may call the other "lateral rotation of the legs and flatfeet," in which case the entire leg will be rotated laterally from the hip, and the feet will be flat. There are a number of variations, but most children affected will fall into one of these two classifications.

Both deformities are produced by the way the baby sleeps during the first fourth months when he cannot turn over, and from the way he sits before he starts walking. If he persists in sitting in the same position, the deformity becomes fixed. If he sits in various positions, the deformities will gradually disappear.

In the past we have tried to explain bowlegs and knock-knees in several ways. We have explained it on a chemical theory postulating that there was a lack of some element, as a lack of calcium in the bones. We have explained it on a vitamin theory, postulating there was a lack of a vitamin, as a lack of vitamin D. We have given too little thought to the possibility that mechanical pressure may play an important role in the production of deformities in the limbs.

In the past when we saw a child with flatfeet we paid little attention to what might have caused the feet to be flat. We assumed that he was born that way, or we accepted at full value the mother's statement that the baby inherited the flatfeet from his father.

Today the pediatrician and the orthopedist are spending more time in trying to prevent disease and deformities than they are in treating them.

The purpose of this paper is to analyze the cause of pigeon toe deformity and flatfoot deformity, and give suggestions as to how they might be prevented.

Lateral Rotation of Legs and Flatfeet

The diagnosis, "lateral rotation of the legs and

flatfeet" is used to describe what is seen when the child is examined. The two conditions go together.

After birth, a stiff, new diaper which is much too large for the baby is applied; this is pinned tightly and holds the legs at right angles to the body. The knees are flexed. The baby is placed on his stomach or back. (Fig. 1.) In either position the thighs are rotated outwardly 90 degrees at the hips. He stays in this position most of the time day and night, until he is old enough to turn. The muscles and ligaments about the hips become stretched and are fixed in this position of outward rotation. When he is old enough to stand the entire leg is rotated laterally from the hips, so that we might say that "one foot goes east and one goes west." The legs can be passively turned outward until the patellas point laterally 90 degrees,

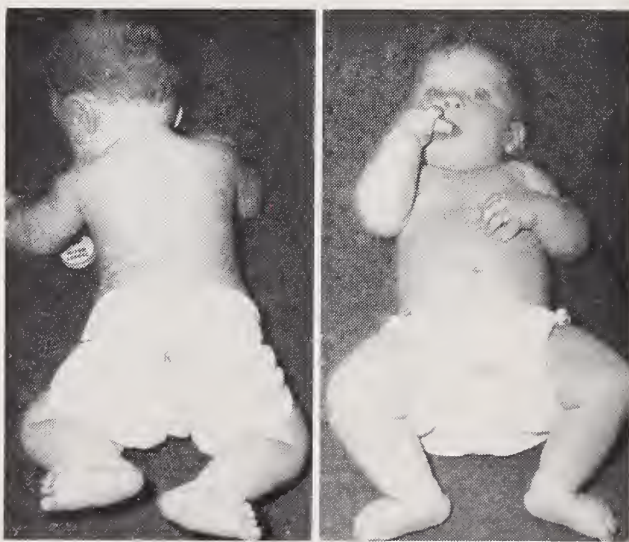


Fig. 1-A. The baby who sleeps in a "frog" or "spread-eagle" position, develops lateral rotation of the legs, in the hips. (The younger baby shows it better than this older one used in this picture.) When placed on the abdomen with the thighs abducted 90 degrees, the flexed lower legs will cause the thigh to be rotated laterally 90 degrees in the hips. The great toe rests on the mattress and bends the foot in the midtarsal joint into a flatfoot position. The shortened peroneii tendons pull in a direct line, and pull the foot out and up into a calcaneovalgus or flatfoot position.

Fig. 1-B. When placed on the back, the legs are still rotated laterally 90 degrees at the hips. With the leg in an outwardly rotated position, the heel rests on the mattress, and the weight of the forefoot carries the foot out into a flatfoot position.

and the legs can be rotated medially only until the patellas point straight forward. He will walk with the legs rotated at the hips about half way between these two limits.

While this laterally rotated position is becoming established, gravity is producing a flatfoot. If the baby is sleeping on the abdomen, the great toe rests on the mattress, and the foot is bent in the midtarsal joint. The forefoot is forced into an abducted position. This also everts the heels to a valgus or flatfoot position. If the baby sleeps on his back, the heel rests on the mattress, and the weight of the forefoot in the outwardly rotated position also twists the foot into a flatfoot position.

After gravity produces a flatfoot type of architecture, the muscles pull the foot into a more marked flatfoot position. The peronei muscles are in a shortened position, which gives them more power because they pull in a more direct line, and thus they work at a mechanical advantage. The tibial muscles are stretched and are in a weakened position. They have to pull from around the corner and work at a mechanical disadvantage. These are the mechanical factors which are responsible

for producing a calcaneovalgus or flatfoot deformity.

Bowlegs and Pigeon-Toe Deformity

The other pattern of deformity is presented by the infant who is bowlegged and pigeon-toed when he begins to walk. The parents complain that he stumbles over his feet and that he cannot run without falling. This child when first seen has usually been put on extra cod liver oil by the pediatrician, who thought that he might have rickets. This deformity is not due to rickets, but it is also produced by the position in which the baby sleeps and sits.

Medial torsion of the limbs may be divided into two groups, according to the etiology.

1. Acquired medial torsion, which is common.
2. Congenital medial torsion, which is rare.

Acquired Medial Torsion

Before birth the infant has been floating in amniotic fluid, with the knees and hips flexed. After birth he is placed on a firm mattress, with his legs straight. He is unhappy and cries. When he is placed on his abdomen with the knees doubled up under him in the fetal position, he goes to

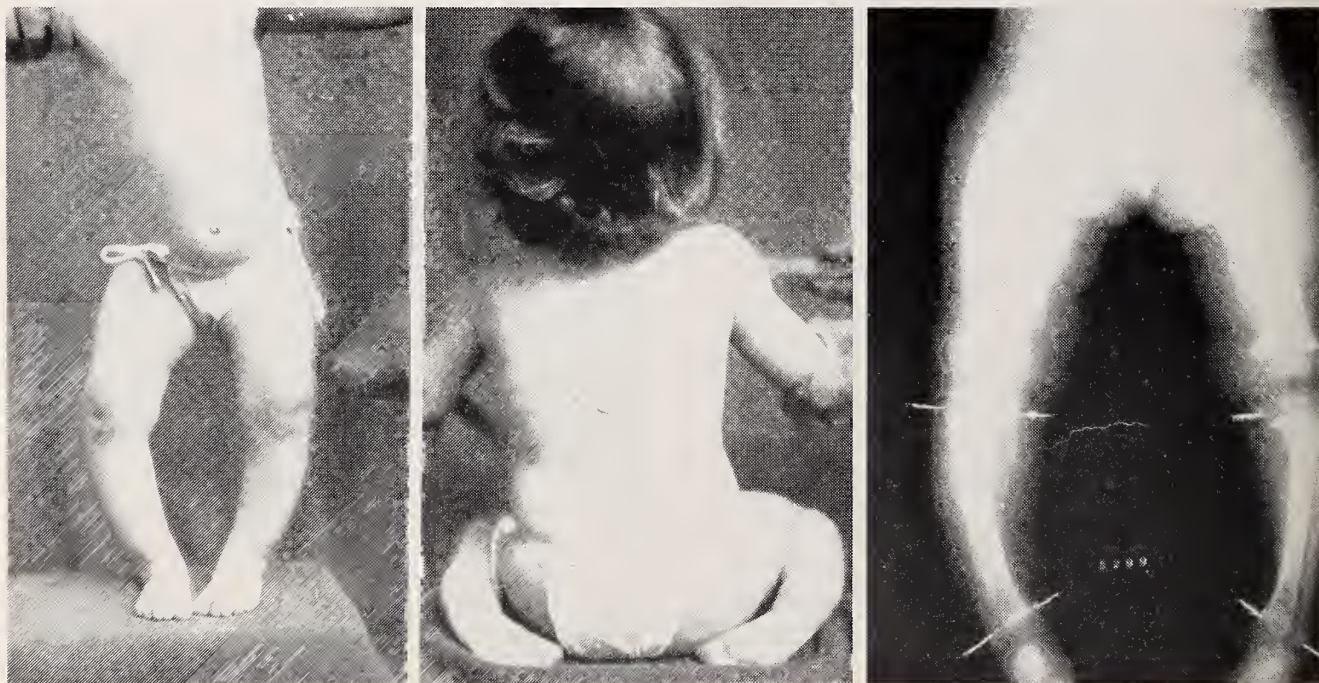


Fig. 2-A. Girl, 17 months old with bowlegs and pigeon-toes. She stands with her feet pointing nearly straight forward, but she shows more turning in of the feet when she walks. When the patellas are made to point straight forward the feet turn inward about 45 degrees. When the feet are made to point straight forward the patellas must point outward about 45 degrees. There is an inward twist between the knee and ankle. Also some lateral convexity of the lower legs. Because of the strain, there is more relaxation of the joints, and a lateral wobble can be obtained in the knees.

Fig. 2-B. When this same child was allowed to sit, she always sat with her feet under her. This was her "position of

comfort." The anterior surface of the thighs is rotated medially, fixing the ligaments about the hips in medial rotation. The position of the feet twists the ankles and knees medially, giving a medial twist to the lower leg. Often the convexity of the buttock fits into the concavity of the foot, as the patient sits on her feet and puts more strain on the legs.

Fig. 3. In the roentgenogram the soft part shadow shows a lateral convexity which gives the leg the appearance of being bowed. However, the shafts are straight. The angulation takes place at the epiphyseal lines. These lines are not perpendicular to the midline of the shaft, but form an angle which converges medially. The bones never show any cupping or wide epiphyseal space as seen in rickets.

sleep. This soon becomes his "position of comfort." He continues to sleep with his knees drawn up under him, his hips up in the air and both feet turned in toward each other in a pigeon-toed position.

Sometimes mothers say that the pediatrician has suggested this position to help get the gas off the stomach. The mothers like the knee-chest position because the baby is less apt to kick off the cover. The baby who sleeps in this position will crawl with the feet turned in toward each other, and when he sits, he straightens up on his knees and sits back on his lower legs with the feet turned in. (Fig. 2.) Sitting on the inverted feet also puts a medial twist in the lower leg between the knee and ankle. When he stands, he may stand with his feet pointing straight forward, but when he walks the entire leg is rotated medially from the hips.

In the roentgenograms the soft part shadow of the lower leg appears to be curved, but the shafts of the tibia and fibula are straight. (Fig. 3.) The deformity is due to a change in the relationship of the epiphyseal line to the shaft. The epiphyseal lines instead of being perpendicular to the shaft form an angle at each end, with the lines converging on the medial side. There is always more angulation at the ankle than at the knee. This gives the appearance of a lateral convexity to the lower leg.

Congenital Medial Torsion

These babies are born with medial torsion and

lateral convexity of the lower leg. The parents or pediatrician notices the bowleg deformity at birth. This deformity has been described by Nachlas¹ who says that it may be an atavistic reversion or a developmental arrest. The orangutan and the gorilla show medial torsion of the leg. So did prehistoric man. The human fetus in its development shows an inward torsion of the tibia. This disappears during the last two months before birth as a rule. When it does not disappear we have congenital medial torsion. The developmental arrest theory is the more acceptable to the parents.

It is sometimes difficult to distinguish between the congenital and the acquired types of medial torsion. The "rotation test" assists in separating the two. (Fig. 4.) If it is congenital, we can rotate the legs laterally and medially about the normal amounts. If the medial torsion is acquired, we can rotate the legs medially until the patellas point inward a full 90 degrees. The legs cannot be rotated laterally much past the midline. It is important to distinguish between the two, because the treatment is more difficult in the children born with medial torsion.

Treatment

To prevent either medial or lateral torsion of the legs, the baby should be taught to sleep on its side. When placed on the side with the hips and knees gently flexed, the anterior surface of the thigh and the anterior surface of the abdomen are in the same plane. This is true for the upper leg



Fig. 4-A. Two year old girl with medial torsion of the legs and some bowing.

Fig. 4-B. She sits with knees flexed and feet near the hips. This rotates the anterior surface of the thighs medially. The constant sitting in this position fixes the hips in this position. In order to determine whether this is "acquired" or "con-

genital" medial torsion, do a "rotation test."

Fig. 4-C and D. The legs can be rotated medially 90 degrees or more, but cannot be rotated laterally much past the midline. Therefore, it is "acquired" medial torsion in this case. If the legs could be rotated each way the normal amount, it would be "congenital" medial torsion.

as well as for the lower.

The baby can be taught to sleep on his side by placing a small pillow under the hips and shoulders. Such a support can be made by rolling up a baby blanket and tying strings around it, and making it like a log. After one feeding the baby is placed on one side and after the next feeding on the other side. This also prevents deformities of the jaws and gives a better shaped head. The baby should never be placed on his back after a feeding, because of the danger of regurgitating and strangling. He should be placed on his stomach when awake for exercise.

The "lateral rotation of the legs and flatfeet" are corrected by having the mother grasp the knees and rotate the legs medially as far as they will go comfortably; hold them in this position for a half minute; release them, and repeat the process. The mother is also taught how to turn the forefoot down and to correct the flatfoot deformity.^{2 3 4} The mother should spend at least 10 minutes on these exercises night and morning. In order that it not be forgotten, it should be made a part of the daily routine. It can be done after the morning bath and during the preparation for bed. These manual manipulations will correct most cases. If the treatment has been started late, the child may need a bar across the shoes to be worn at night to turn the legs medially. The bar may be bent toward the body, so as to invert the feet and help correct the flatfoot deformity.

The "medial torsion of the legs" is corrected by the mother's grasping the knee and ankle and turning the foot laterally, so as to untwist the lower leg.⁵ This is best done with the hand on the medial side of the foot. The lower leg is strained laterally for a half minute and released and the stretching repeated. This is done like wringing clothes. The lateral convexity is corrected by the mother, standing at the side of the baby, grasping the knee with one hand and the ankle with the other. She places her thumbs on the lateral side of the lower leg over the fibula and presses inward with the thumbs, like in straightening a wire. Usually these manipulations will correct the acquired type of medial torsion. In the late cases a bar may be placed across the shoes to be worn at night to hold the legs in an outwardly rotated position. This also keeps the baby from sleeping in the knee-chest position.

The "congenital" medial torsion case should first have this same treatment, and, if the legs do

not respond, a double leg brace may be needed. (Fig. 5.) If applied before the child is two and a half years old, this will correct the deformity in four to six months. However, only an occasional case will need the double leg braces.



Fig. 5. Showing the type of brace used for "congenital medial torsion" to correct the bowleg and pigeon-toe deformity. The long lateral bars of the brace are attached to the pelvic band in such a way as to rotate the legs laterally. There is also an additional twist between the knee and foot to turn the foot outward. This corrects the medial torsion. The lateral convexity of the lower leg is corrected by pressure at three points. There is a pad on the medial side of the knee and a strap around the medial malleolus and lateral bar. This fixes each end of the lower leg. The strap which goes around the middle of the lower leg is attached to the medial bar but is not attached to the lateral bar. Tightening the straps makes pressure on the lateral side of the leg and corrects the lateral convexity.

Summary

Torsion of the legs in small children usually takes one of two forms. They may have medial torsion and be bowlegged and pigeon-toed, or they may have lateral torsion and be flatfooted. The earlier the condition is recognized the easier the correction. It is not safe to assure the parents that the deformity will correct itself spontaneously.

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abstracts by georgia authors

Chambers, William R., 101 Third St., N.E., Atlanta, Ga. "A Follow-up of the Early Operation for Myelocoele and Meningomyelocoele on Ten Unselected Cases." Am. J. Surg. 88:552-558 (Oct.) 1954.

Early operation for spina bifida is recommended by the author on the basis that the worst cases, which present a parchment-like sac, are susceptible to infection for which the baby is poorly prepared. Without intending to recommend that all babies with spina bifida be operated, 10 unselected cases were subjected to surgery within a very short period after birth. A technique enabling the surgeon to avoid cutting essential structures was described in the *American Journal of Surgery* three years ago. The present paper describes the results in these unselected cases, two to three years post-operative. In spite of what may have appeared at first to be a very unfavorable prognosis, the sacs being very large and containing neural elements, the results have been better than might have been expected. Of the 10 cases seven have been brought through to what promises to be a useful life. Two of the ten developed hydrocephalus and one died of intercurrent disease. Photographs and reports of the children's pediatricians are presented to show that of these seven, six are doing exceptionally well, mentally and physically. The seventh cannot walk but could not use the legs before operation. Enuresis appears to be the most persistent difficulty and further study must be given before it can be brought under satisfactory control in all. The inference is drawn that many more spina bifida cases with meningocele can be given a satisfactory prognosis if operation can be undertaken before severe infection invades the parchment sac. Operation is recommended in the first 24 hours of life.

Greenblatt, Robert B., Hammond, D. O., Clark, Sarah L., Medical College of Georgia, Augusta, Ga. "Membranous Dysmenorrhea: Studies in Etiology and Treatment." Am. J. Obst. & Gynec. 68:835-844 (Sept.) 1954.

A patient receiving daily doses of 50 to 75 mg. of progesterone intramuscularly for 31 consecutive days passed an endometrial cast of the uterus. Another patient receiving daily doses of 25 mg. of progesterone passed a cast on the 15th day with severe pain. The accidental induction of a decidual cast in this manner lends support to the theory that membranous dysmenorrhea represents a hyperprogestational response.

A new approach to the management of patients with membranous dysmenorrhea by the continuous suppression of ovulation for a period of one year is presented. This method proved most efficacious in two patients and was accomplished by administering oral estrone sulfate continuously and interposing small doses of anhydrohydroxyprogesterone for five days at monthly intervals to induce withdrawal periods.

Androgen therapy (in the form of pellet implantation), though not as efficacious as estrogen therapy, nonetheless proved temporarily effective in management of three patients with membranous dysmenorrhea.

Uterine physiology may be so modified by therapy that passage of a membranous cast may occur without pain.

Edmundson, Walter F., Ackerman, John H., Gutierrez-Salinas, Euardo, and Olansky, Sidney, Chamblee, Ga. "Study of the TPI Test in Clinical Syphilis." AMA Arch. Dermat. & Syph. 70:298-301 (Sept.) 1954.

In 15 patients, who had no history of previous antisyphilitic treatment, with dark-field positive primary lesions of syphilis, seronegative in the VDRL slide flocculation and Rein-Bossak slide, flocculation quantitative tests, 14 were found to be seronegative with TPI tests; one patient was found to show a reactive TPI test.

Five of 15 dark-field positive seropositive (in VDRL slide and Rein-Bossak tests) patients were found negative with the TPI test; 10 were reactive in the TPI.

All of 20 patients who had no history of previous treatment for syphilis, with dark-field positive seropositive secondary syphilis, were found reactive in the TPI test.

The TPI test is not recommended as a diagnostic procedure during the primary or secondary stages of syphilis. It is

evident that this TPI test is not as sensitive in detecting early syphilis infection as the VDRL slide flocculation or Rein-Bossak slide flocculation tests.

Active infectious syphilis may be present in the patient who has reactive or nonreactive STS (VDRL slide or Rein-Bossak) and nonreactive or reactive TPI test results. This should be considered in interpreting TPI test results, and points out the necessity for the physician to relate clinical findings to laboratory test results.

Richardson, Arthur P., Moran, Neil C., and Perkins, Marjorie E., Emory Univ. School of Medicine, Atlanta, Ga. "The Action of Andromedotoxin on the Carotid Sinus in Dogs." J. Pharmacol. & Exper. Therapy. 111:454-458 (Aug.) 1954.

The action of andromedotoxin on the carotid sinus in vagotomized dogs has been investigated. Doses of intravenously administered andromedotoxin (8-20 microgm./kgm.) which are consistently hypotensive in vagotomized dogs either show no response or produce a pressor effect after bilateral denervation of the carotid sinus area.

Injections of minute doses of andromedotoxin (0.5 to 0.1 microgm.) into the adventitia of the innervated carotid sinus in vagotomized dogs with unilateral carotid sinus area denervation produce consistent depressor effects with partial or complete blockade of the carotid pressor reflex. Control injections of saline in equal volumes (0.1 ml.) are without effect. Rapid denervation of the carotid sinus during the hypotensive phase results in a sudden rise in blood pressure to hypertensive levels after which andromedotoxin by the intravenous route or by carotid sinus injection fails to produce a fall in pressure.

Andromedotoxin administered either intravenously or into the carotid sinus adventitia in two debuffed dogs with intact carotid bodies failed to elicit depressor responses. The latter structures, therefore, apparently play no role in this hypotensive action.

Neogermirine and protoveratrine also showed the same type of responses demonstrating a close similarity in action between andromedotoxin and these veratrum alkaloids.

It is concluded that the hypotensive action of andromedotoxin is entirely reflex in nature. No central vasodepressor action has been demonstrated.

Fish, John S., Bartholomew, R. A., Colvin, E. D., Grimes, W. H., Jr., Lester, W. M., 272 Boulevard, N.E., Atlanta, Ga. "Diagnosis and Management of Late Pregnancy Hemorrhage." Sou. Med. J. 47:954-960 (Oct.) 1954.

The proposition is restated that abruptio placentae is a manifestation of toxemia of pregnancy. This is supported by the presence in the placenta of abruptio of the acute hemorrhagic infarct which is characteristic of preeclampsia and eclampsia and which is the probable source of excessive thromboplastin resulting in diffuse fibrin embolization and its sequelae characteristic of abruptio and toxemia. This concept speaks for conservatism in management to avoid unwarranted maternal risk. Employing blood transfusion, rupture of membranes and vaginal delivery in the treatment of abruptio, the authors avoided maternal death and serious complications such as lower nephron nephrosis, cortical necrosis and afibrinogenemia and salvaged 86 per cent of infants over 1500 grams who were alive on admission to the hospital.

Painless hemorrhages of late pregnancy are not necessarily due to placenta previa. On the contrary, over half are from marginal sinus rupture in normally implanted placentae. In all the latter and in many placenta previas, abdominal delivery is unjustified. Decision as to delivery route is based on vaginal examination, and the accuracy of evaluation of the cervix and placental location as well as the safety of this procedure are enhanced if it is postponed until the delivery route must be chosen. Expectant management is applicable in one-third of cases and sharply reduces fetal loss from prematurity while not increasing maternal risk. Contraindications to expectancy are definite and considerations of maternal safety demand strict adherence thereto.

McAllister, Robert W., 700 Spring St., Macon, Ga. "Urinary Incontinence as Related to General Practice." *Sou. Med. J.* 47:949-953 (Oct.) 1954.

The classifications of enuresis are many and confusing, particularly to the casual surveyor of the subject. It is logical that the simplest and most stimulating classification of urinary incontinence from a diagnostic point of view should relate directly but in a general way to the basic pathologic phenomena which can involve the bladder and lower urinary tract to the extent that uncontrollable leakage takes place. On this thesis, I submit the following classification:

CLASSIFICATION

Basic Pathologic Phenomena

- (1) Emotional
- (2) Irritative
- (3) Obstructive
- (4) Traumatic
- (5) Neurogenic
- (6) Anomalous (urinary tract)
- (7) Malignant degenerative

A careful history, a thorough physical examination and thoughtful consideration of the above phenomena should be extremely helpful from a diagnostic point of view in urinary incontinence.

A case of ureteral ectopia with urinary incontinence in a female child followed by surgical cure was reported. All physicians are urged to become aware of this lesion as a cause of urinary incontinence in the female.

Olansky, Sidney, Edmundson, W. F., Harris, Mr. Ad, and Rambo, Dorothy S., R. N., Chamblee, Georgia. "Negative Kahn Standard and Positive VDRL Slide Tests for Syphilis." *AMA Arch. Dermat. & Syph.* 70:282-288 (Sept.) 1954.

A large percentage of patients selected on the basis of blood tests showing some reaction in the VDRL slide test and negative findings in the Kahn standard test were found to have syphilis or to have been treated for this disease.

A greater number of positive TPI test findings may be expected in this patient category than would be obtained when complement-fixation or flocculation tests for syphilis reagin.

Positive TPI results may occur in the absence of clinical or historical evidence of syphilis and negative findings with this test may be associated with strong evidence of syphilis infection.

Serologic tests for reagin and the TPI antibody are valuable aids in the detection of syphilis but should not be considered to be, of themselves, diagnostic of the presence or absence of syphilis infection.

Richardson, Arthur P., Moran, Neil C., and Perkins, Marjorie E., Emory Univ. School of Medicine, Atlanta, Ga. "Veratridine Blockade of the Carotid Sinus Pressoreceptors." *J. Pharmacol. Exper. Therap.* 111:459-468 (Aug.) 1954.

Injections of small doses of protoveratrine (0.1 microgm.), neogermirine (0.05 microgm.), and andromedotoxin (0.1 microgm.) into the adventitia of the innervated carotid sinus of vagotomized dogs with unilateral carotid sinus denervation

result in a fall in arterial blood pressure and blockade of the carotid sinus pressor reflex.

Veratridine injected in a similar manner has no effect at a dose of 0.1 microgm., but at 0.5 to 1 microgm. causes a pronounced rise in arterial pressure with a blockade of the carotid sinus pressor reflex. Subsequent administration of andromedotoxin, protoveratrine or neogermirine, either into the carotid sinus adventitia or intravenously, fails to produce a depressor response. Veratridine injected into the carotid sinus adventitia during the hypotensive phase of one of the other drugs causes a sharp pronounced pressor response similar to surgical denervation of the sinus.

Veratridine administered intravenously to vagotomized dogs with intact carotid sinuses in doses sufficient to abolish the carotid sinus pressor reflex prevents the depressor action of intravenously injected andromedotoxin.

After denervation of the carotid sinuses in vagotomized dogs in which the carotid bodies are left intact (as determined by the hyperpneic response to intravenously administered sodium cyanide) veratridine, injected into the carotid sinus adventitia, is inactive.

It is concluded that drugs such as protoveratrine, neogermirine and andromedotoxin cause a stimulation of the carotid pressoreceptors while veratridine produces a blockade of these receptors, after an initial transient stimulation.

Rieser, Charles E., 819 Cypress St., N.E., Atlanta, Ga. "Medical Management Aimed at Prevention of Recurrence in Calculous Disease." *Sou. Med. J.* 47:935-938 (Oct.) 1954.

The author describes the various extra urinary tract factors which contribute to the formation of urinary calculi. Hyperparathyroidism, immobilization, Vitamin D excess and dietary calcium are discussed. Hyperparathyroidism pulls calcium from the bone mass producing hypercalcinuria. Immobilization causes some stasis in emptying the renal pelvis plus osteoclastic resorption of bone due to disuse resulting in hypercalcinuria. Vitamin D excess increases absorption of calcium from the intestinal tract and mobilizes calcium from the bones effecting hypercalcinuria. Increased dietary intake of calcium allows the unused excess to be excreted through the kidneys. Alteration of the urine by dietary or medicinal means so that the calcium salts which do reach the kidney will have the greatest possible solubility is analyzed. Obstructions with stasis favors calcium precipitation. Urinary infections encourage stone formation by increasing precipitation of calcium. Urinary acidification markedly influences the solubility of calcium phosphate and magnesium ammonium phosphate. Foods which cause alkaline urine should be forbidden. Excess water intake particularly during hot weather reduces the concentration of calcium in the urine. Administration of estrogens increases the secretion of citric acid by the kidney. Citric acid offers a protective mechanism against stone formation by increasing calcium phosphate solubility. The role of hyaluronidase and its influence on the protective urinary colloids is too early to evaluate.

Parrot Fever Is Not So Rare

Parrot fever, commonly believed to be a rare disease caught only from parrots and parakeets, probably is not so rare and even can come from chickens, turkeys, and ducks.

Thirty-seven cases of parrot fever, or psittacosis probably caught from chickens were found during six months in the rural area around Warren, Illinois. The cases were reported in the July 24 *Journal of the American Medical Association*.

Investigation of possible sources of the disease showed chickens to be "the only potential reservoir commonly associated with these cases." Not all resulted from direct contact with chickens. One

patient had cleaned a chicken yard two weeks before his illness; another had an apparently well parakeet; and another had an apparently well canary.

Besides a severe cough which was the chief complaint, the patients had chest pain, fever, headaches, muscular aches and pains backaches, and weakness or fatigue. All of the patients recovered.

In any case of virus pneumonia or chronic cough occurring in persons in rural areas, the report indicates the possibility of psittacosis infection should be considered.



doctor placement page

NOTE: The Medical Association of Georgia assumes no responsibility for information herewith printed—it is for information only. Anyone interested is advised to make such investigations for verification as he deems necessary.

AVAILABLE PHYSICIANS

MacKavanagh, James L., M.D., 160 Marion Avenue, Marrick, L. I., New York, age 44, married, Roman Catholic, graduate Georgetown University Medical School, 1934, presently in general practice, wishes to relocate, priority 3, interested in general practice in Georgia, size of community not too important, available within two or three months after location is selected.

Stark, C. V., M.D., Box 109, Arcadia, Fla., wants practice in Georgia during spring of the year only, as he spends winters in Florida, born November 25, 1878, widower, graduate Oploma Medical University, Tenn., 1900, specialty—general medicine, population 1,000 or more.

Shanahan, John Rush, M.D., 10310 Greenfield Street, Kensington, Maryland. Age 39. Married; Roman Catholic. Graduate Georgetown University, 1948. Residency U. S. Naval Hospital, Bethesda, Maryland. Priority 5. Specialty—Internal Medicine. Desires community in Georgia of 20,000 to 30,000. Available June, 1955.

McCoy, John M., (Capt. 059752), 121st Evacuation Hospital, APO 971, c/o Postmaster, San Francisco, California; age 31 married, 2 children; Presbyterian; graduate Duke University, 1947; residency - George Washington University Hospital, VA Hospital; eligible to take Part II, American Board of Internal Medicine; available March 1, 1955.

Upchurch, Kent P., 215 Pine Valley Road, Winston-Salem, N. C.; age 30; married; Protestant; graduate Bowman Gray School of Medicine, 1946; Board qualified in Ob and Gyn; interested in group practice or woman's clinic as an assistant or associate; available September 1, 1954.

Berry, Bradley D., M.D., Whitfield, Mississippi; graduate Jefferson Medical College, Philadelphia, Pennsylvania; completed internship; interested in general practice in Georgia.

Crupie, Joseph E., M.D., 347 Plant Street, Apt. 4-F, Tampa, Florida; age 30; married; graduate University of Tennessee School of Medicine; 1953; Priority IV; interested in general practice in Georgia; available 1st week in February 1955.

Frerichs, Cletus T., M.D., 1221 Sixth Avenue, S.E., Rochester, Minnesota; age 30; married, two children; Lutheran; graduate University of Nebraska School of Medicine, 1947; 3 year fellowship in

internal medicine at the Mayo Foundation; specialty—internal medicine; prefers community of 15,000 up; available January 1, 1955.

Stewart, Lena M., M.D., 250 N. Ottawa Street, Joliet, Illinois; age 65; single, Methodist; graduate Chicago College of Medicine and Surgery; 1917; residency—Deaconess Hospital; presently in practice, desires a milder climate; interested in general practice for girls school or student health; available November 1, 1954.

Watson, Alfred Lawrence, M.D., 1415 Titus Road, Memphis 11, Tennessee; age 29; married; Methodist; graduate Vanderbilt University School of Medicine, 1949; residency—2 years at Grady Hospital, Atlanta in internal medicine and at Kennedy Veterans Hospital, Tennessee; Priority IV; specialty internal medicine; prefers clinic, assistant or associate; available July 1, 1955.

Brooking, Donald G. W., M. D., 228 Finley Drive, Decatur, Alabama. Age 33; married; Protestant; graduate University of Minnesota, 1948; residency Brooke Army Hospital and Cornell University Medical College; passed examinations for certification by American Board of Dermatology and Syphilology; interested in Dermatology in a clinic, as assistant or associate or industrial; available immediately.

Calisch, Louis H., M.D., U. S. Naval Hospital, Charleston, S. C. Age 31; married; Jewish; graduate University of Virginia Medical School, 1947; residency Johnston-Willis Hospital; finishing 27 months of active duty; specialty internal medicine; available January 1, 1955.

Collins, Douglas, M.D., 172 Riverside Park, Iowa City, Iowa. Age 33; married; Methodist; graduate University of Alabama School of Medicine, 1951; residency State University of Iowa Hospital; specialty Ob-Gyn; available July 1, 1955.

Gianoulis, James T., M.D., 611 West Grace Street, Richmond 20, Virginia. Age 38; married; graduate Medical College of Virginia, 1941; interested in general surgery and gynecology; Priority IV; six year surgical residency at Medical College of Virginia Hospital; looking for a permanent location with a future.

Gwinn, John L., M.D., 1309 Third Avenue, S.W., Rochester, Minnesota. Age 32. Married; Protestant; graduate University of Louisville, 1946; residency Mayo Clinic; finishing a fellowship in pediatrics; priority IV; specialty pediatrics; prefers practice in Georgia; available January 1955.

Hunter, I. H., M.D., 204 East Hill Avenue, Valdosta, Georgia; age 73; married; Missionary Baptist; graduate Grant University, 1903; interested in general practice;

specialty pediatrics; prefers community of 1,000; will accept good position with clinic; available immediately; been in active practice for 50 years.

McConnell, Ben H., M.D., Box 664, Beltsville, Maryland. Seeking position as a student health physician. Age 36; married; Episcopal; graduate Georgetown University, 1950; interested in general practice as student health physician with any school, college or university; available at once.

McGarry, Paul A., M.D., Charity Hospital, New Orleans, Louisiana. Age 26. single; Roman Catholic; graduate Temple Medical School, Philadelphia, Pennsylvania 1954; presently interning; 2A Priority 3; interested in general practice in a rural area; available August 1955.

Scruggs, W. H., M.D., Bryson City, N. C. Age 65; limited general practice; 1 year in TB work, 3 years in general surgery; licensed in Georgia; married; Baptist; graduate University of Maryland, 1913; prefers small town with hospital. Available immediately.

Vildibill, James Wm., M.D., 919 Ford Street, Corona, California. Age 29; married; Presbyterian; graduate Tulane, 1948; residency Charity Hospital; presently in USN; specialty urology; prefers practice in Georgia; available no later than November 1, 1954.

Marder, Leon, M.D., 323 East Chestnut Street, Louisville 8, Kentucky. Age 32; married; Hebrew; graduate University of Oklahoma, 1949; residency St. John's, General and Michael Reese Hospitals; specialty internal medicine; wishes to associate or share office space with another physician or enter private practice in a community where vacancies exist; available July 1, 1955.

Peake, Charles O., M.D., 844½ Ninth Avenue, S.E., Rochester, Minnesota. Age 27; married; Methodist; graduate University of Pennsylvania, 1951; residency Mayo Foundation; Priority IV; specialty Ob-Gyn; interested in locating in Georgia particularly Atlanta; available July 1, 1955.

Sharp, Thomas B., Jr., M.D., 1530 Shoup Court, Decatur, Georgia; age 28; married; Protestant; graduate Emory University, 1950; residency Lawson VA Hospital and Grady Memorial Hospital; military requirements fulfilled; specialty internal medicine; clinic preferably; available July 1, 1955.

Vetter, John S., M.D., Grady Memorial Hospital, Atlanta, Georgia. Age 26; single, Baptist; graduate Duke University, 1953; rotating internship; interested in general practice; any size community; would like to work for general practitioner on vacation, etc., for month of January while waiting to be called to Air Force.

AVAILABLE LOCATIONS

Meigs, Georgia - Thomas County - one doctor's clinic available, with ample space for a two doctor set-up; one aged doctor; hospital facilities nearby; good schools; paved highways; contact: Mr. O. H. Lewis, Meigs Clinic, Inc., Meigs, Georgia.

Pearson, Georgia - Atkinson County - will furnish house and equip clinic; new

Hill-Burton Hospital at Douglas guarantees staff privileges to GP; office will be rent free for six months; contact Mr. Barney Kraft, Pearson, Georgia.

Villa Rica, Georgia (Carroll County) New 24 bed HB hospital to be built soon. Now have seven bed hospital. Office available for lease, reasonable. Housing available at reasonable cost. 12 grade accredited school. (Pop. 3,200). Contact: Mr. Edgar P. Candler, Villa Rica, Georgia.

Bremen, Georgia—Haralson County— Need an associate in field of obstetrics and gynecology. Completing a modern office building to house the group and about October 1st new 29 bed hospital should be in operation. Group consists of three physicians—2 in surgery and 1 in medicine and anesthesia. Would have all the work he could handle in ob and gyn. Contact: Dr. J. H. Pritchett, Jr., Bremen Hospital, Bremen, Georgia. (Population 3,500).

Marietta, Georgia—Cobb County—Interested in Negro physician to replace present physician who is going into armed forces. Contact Mr. Millard L. Wear, Administrator; City of Marietta Hospital Authority; Kennestone Hospital, Marietta, Georgia.

Jeffersonville, Georgia—Twiggs County—Only doctor in county is in his 70's and has been doing limited practice. Contact Mr. H. C. Swearingen, Jeffersonville, Georgia. (Population 1,000).

Woodbine, Georgia—Camden County—Small fully equipped and stocked office and clinic immediately available; ample office space, delivery room, laboratory (including x-ray), nursery, wards and private rooms; can be used as office,

clinic or small hospital; 5 room wooden dwelling adjoins to hospital, available at \$35.00 per month or other houses for rent or sale; one other doctor in Woodbine. Doctor is needed now. Contact: Dr. Sam C. Atkinson, Waverly, Georgia. (Population 1,000).

Roberta, Georgia—Crawford County—No physician in area, county maintains a large home with most reasonable rental available for resident doctor. Plans for clinic nearing completion, immediate use of rooms in present clinic building, also three rooms over post office ready for use, year's rent free. Excellent opportunity for qualified physician looking for general practice. Contact Mr. J. Welborn Johnson, P. O. Box 143, Roberta, Georgia.

Arlington, Georgia—Calhoun County—In need of a doctor-surgeon for practice in new excellently equipped 161 bed hospital located to serve Calhoun, Baker, Early and Clay counties. Office space and home available. Contact: Mr. Carter Ray, Arlington, Georgia. (Population 1,382).

Attapulgus, Georgia—Decatur County—Present doctor unable to practice on full scale; has clinic with waiting rooms for white and colored patients, x-ray, cardiogram, metabolism, pneumothorax, violet ray and laboratory equipment. Town is centrally located with access to hospitals. Present doctor will reserve working space in the clinic, will sell outright or lease the clinic at very nominal figure. Contact: Dr. Carl B. Welch, Attapulgus, Georgia. (Population 800).

State Board of Medical Examiners

The following physicians were issued licenses by the State Board of Medical Examiners to practice medicine in the State of Georgia:

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| <p>7320 Henry Shurtleff Barker, Jr., 291 E. Cherry St., Jesup, Ga.</p> <p>7321 John Paul Carter, 908 Kilmer St., Chattanooga, Tenn.</p> <p>7322 Scott Farnum Coffin, Jr., 444 Drayton St., Savannah, Ga.</p> <p>7323 Jerome Alexis Cope, Battey State Hosp., Rome, Ga.</p> <p>7324 Ray Daniel Cramer, Milledgeville State Hosp., Milledgeville, Ga.</p> <p>7325 Richard Duane Crone, Rt. 4, Athens, Ga.</p> <p>7326 John Rafter Derrick, Toccoa, Ga.</p> <p>7327 Joseph Preston Doyle, Camilla, Ga.</p> <p>7328 James Bertram Ellison, 271 Lee St., S.W., Atlanta, Ga.</p> <p>7329 John Anthony Ferrence, Whigham, Ga.</p> <p>7330 B. Shannon Gallaher, Medical College of Ga., Augusta, Ga.</p> <p>7331 Clarence Rolland Gosha, 1124 West 51st St., Savannah, Ga.</p> <p>7332 Arthur Theodore Haebich, 2080 N. Decatur Rd., Apt. 25, Atlanta, Ga.</p> <p>7333 John Allen Hightower, 502½ G St., Brunswick, Ga.</p> <p>7334 Thomas Cruikshank Hill, Jr., 3509 La-Vista Rd., Decatur, Ga.</p> <p>7335 Hezekiah Kent Lewis, 1608 Simpson Rd., N.W., Atlanta, Ga.</p> | <p>7336 Henrietta Jerech, 1323 Munro Ave., Columbus, Ga.</p> <p>7337 Richard Hardin Johnson, Piedmont Hosp., Atlanta, Ga.</p> <p>7338 James Herbert McClure, Dept. of OB & Gyn., Emory Univ. Sch. of Med., 36 Butler St., S.E., Atlanta, Ga.</p> <p>7339 Samuel T. Mercer, 837 Mulberry St., Macon, Ga.</p> <p>7340 Robert Morgan Miller, 552 W. Peachtree St., Atlanta, Ga.</p> <p>7341 Mart Thaxton Pierce, 2108 Stonewall St., Brunswick, Ga.</p> <p>7342 John Bunyan Riggsbee, 131 Osner Dr., Atlanta, Ga.</p> <p>7343 Charles Moncure Smith, White Clinic, Rockmart, Ga.</p> <p>7344 Evelyn McColloch Pebley Stephenson, 3 Raymond Ave., Rome, Ga.</p> <p>7345 Walter Robert Stern, Battey State Hosp., Rome, Ga.</p> <p>7346 Jonathan Simpson Swift, 707 Rosewood Rd., Decatur, Ga.</p> <p>7347 John Foushee Trotter, 520 Church St., Decatur, Ga.</p> <p>7348 Edmund Utkov, Naval Recruiting Sta., Federal Bldg., Macon, Ga.</p> <p>7349 Isom Clements Walker, Jr., 132 E. 52nd St., Savannah, Ga.</p> <p>7350 Karl Rothschild, 149 Livingston Ave., New Brunswick, N. J.</p> |
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MAG Council Meeting

Atlanta, November 4, 1954

THE REGULAR fall meeting of the Council of the Medical Association of Georgia was called to order at 2 p.m., Thursday, November 4th at the Academy of Medicine, Atlanta, by Chairman H. L. Cheves.

The usual date for this meeting was advanced by request of Dr. Wright because of urgent business.

Present were Councilors H. L. Cheves, Union Point; George R. Dillinger, Thomasville; W. G. Elliott, Cuthbert; D. Lloyd Wood, Dalton; Neal Yeomans, Waycross; J. W. Chambers, LaGrange; Mark S. Dougherty, Atlanta. Officers present were Peter B. Wright, Augusta; Milford B. Hatcher, Macon; David Henry Poer, Atlanta; H. Dawson Allen, Milledgeville. Vice-Councilors present were Charles Andrews, Canton (who acted as Councilor in the absence of Bruce Schaefer); Charles T. Brown, Guyton; J. G. McDaniel, Atlanta; Ralph W. Fowler, Marietta; James M. Hicks, Brunswick. Also present were John W. Turner, Atlanta; Spencer Kirkland, Atlanta; Enoch Callaway, LaGrange; J. K. Quattlebaum, Savannah; Eustace Allen, Atlanta; Edgar R. Pund, Augusta; Edgar Woody, Jr., Atlanta; Chris J. McLoughlin, Atlanta, and Messrs. Krueger and Kiser.

The minutes of the last meeting, held September 19th in Atlanta, were read by the executive secretary. Dr. Hatcher asked that the minutes be corrected to read "Dr. Pund's first letter" instead of "Dr. Pund's letter." The minutes were approved as corrected.

District reports, which consisted of evaluations of each county society in the state based on the visitation program by the headquarters office, were presented by Councilors Howard, Dillinger, Chambers, Wood, Yeomans, Cheves and Vice-Councilor Andrews for Councilor Schaefer.

Dr. Poer pointed up the various weak spots in the MAG's 80 component societies and emphasized the need for the Association, through its officers and councilors, to visit these societies that are not functioning and stimulate their organization. Dr. Poer also asked that some consideration be given to the setting up of certain minimum standards for the 80 component societies so that certain societies would have tangible requirements

to meet to qualify as a bonafide county society. He further stated that there is a great need for the profession to have leadership in each county in the state and that when a society is not functioning it weakens the entire Association.

After more discussion by Dr. Poer, Mr. Krueger and Mr. Kiser and members of Council, Dr. Poer moved, seconded by Dr. Elliott, that a committee of Council be appointed to set up minimum standards for a county medical society. This committee is to report back to the next meeting of Council and also refer their findings to the Constitution and By-Laws Committee. Appointed to this committee were Dr.'s Hatcher, Chairman, Yeomans and Wood.

The next item of business to be considered was the request by Dr. Pund, President of the Medical College of Georgia, that Council give its approval to the proposed plans for the Eugene Talmadge Memorial Hospital as approved by the Joint Policy Committee at its meeting on September 26th.

Dr. Wright asked that the executive secretary read the minutes of the September 26th meeting of the Joint Committee on the Policy of the Talmadge Memorial Hospital. Discussion by Dr.'s Callaway, Quattlebaum and Wright, the three MAG members of the Joint Policy Committee, followed.

Dr. Poer reported on a recent meeting of the AMA Council on Medical Service.

Discussion followed by Dr.'s Dawson Allen, Chambers, Poer and Yeomans. Yeomans moved, seconded by Wood, that Council approve the action of the Joint Policy Committee.

Additional discussion followed by Dr.'s Callaway, Eustace Allen, Hatcher, Poer, Yeomans and Wright.

Dr. Pund discussed the proposed policies for the Eugene Talmadge Memorial Hospital from the point of view of the Medical College of Georgia. In his remarks he clarified and explained some of the controversial aspects of the policies.

Dr. Wright proposed an amendment to Dr. Yeomans' motion which made the entire motion read as follows:

"The Council of the Medical Association of Georgia approves the action of the Joint Policy

Committee and goes on record as approving the proposed policies for the operation of the Eugene Talmadge Memorial Hospital and the Medical College of Georgia."

The motion as amended was voted on and carried unanimously.

Dr. Wright then moved that a called meeting of the House of Delegates be held in approximately 30 days in Macon, if satisfactory arrangements can be made. The motion was seconded by Dr. Dillinger, and it carried unanimously.

It was also unanimously approved by Council

that other items of Association business be added to the House of Delegates agenda upon approval of Council.

Dr. Wright asked that all delegates be sent a letter providing them with the necessary information for this meeting.

Other items on the agenda were deferred until the next meeting of Council to be held prior to the meeting of the House of Delegates.

Information was received concerning resignation of the Sixth District Councilor.

The meeting was recessed at 5 p.m.

Journal Editorial Board Meeting

Atlanta, October 20, 1954

THE MEETING of the Editorial Board of the *Journal of the Medical Association of Georgia* was called to order by David Henry Poer, Chairman of the Publications Committee, at 4:00 p.m., Wednesday, October 20, 1954, at the Academy of Medicine, Atlanta.

Present were Edgar Woody, Jr., Atlanta; Ted F. Leigh, Atlanta; Thomas Findley, Augusta; Arthur M. Knight, Jr., Waycross; Arthur J. Merrill, Atlanta; George T. Nicholson, Cornelia; Lester Rumble, Jr., Atlanta; Patrick C. Shea, Jr., Atlanta; Henry H. Tift, Macon; Robert H. Vaughan, Columbus; David Henry Poer, Atlanta; H. Dawson Allen, Milledgeville; Miss Frances H. Porcher, and Messrs. Milton D. Krueger, John F. Kiser and John Stuart McKenzie.

Dr. Poer welcomed newcomers to the *Journal* Editorial Board and introduced the president-elect of the Medical Association of Georgia, H. Dawson Allen. Dr. Allen suggested that the cost of printing the *Journal* should be reviewed, and that new bids should be let sometime in the near future. He also suggested making a concerted effort to sell more subscriptions.

Edgar Woody, Jr., Editor of the *Journal*, outlined the role played by the contributing editors. First of all, they must be interested in the general field of medical writing. Contributing editors are expected to write editorials for the *Journal*, to solicit the contribution of scientific articles and to represent the *Journal* in their respective areas. The contributing editors are the *Journal*; he emphasized the fact that this publication is not the voice of Atlanta, an idea some have because it is published

here, and that it is the responsibility of the contributing editors to make it the voice of the entire state.

The question of publication of Annual Session papers was raised: such papers are the property of the Association to publish as the editors see fit. In view of the fact that these papers have already been presented to the physicians of Georgia, unsolicited scientific papers submitted throughout the year are given equal consideration with Annual Session papers.

Miss Porcher reported on the financial status of the *Journal*. As of October 1, 1954, the printing and engraving costs of the *Journal* had exceeded the advertising income by approximately \$400.00. It is expected, however, that the overall cost of publication will not exceed the yearly income.

The 1955 membership roster of the Association will be published under separate cover, for easy reference, in January. Members will be listed alphabetically, with their specialties noted, and by county society in another list. The question of publishing one directory of all the physicians in Georgia, with the cooperation of the State Board of Medical Examiners, was raised. Mr. Krueger was asked to look into the matter.

Miss Porcher was asked to investigate the advisability of having reprints from the *Journal* handled through the *Journal* office instead of having the author deal directly with the printer as is the way they are.

Dr. Woody asked the advice of the board as to how to improve the "News Notes" section. Dr. Nicholson suggested that a reporter be appointed

from each district to gather and relay news from his district. He suggested that each district councilor be asked to select a reporter in his district since the councilor is in a position to know who would be best able to carry out such duties. As an alternative to this plan, it was suggested that the contributing editors assume the responsibility of sending in news for the "Personals" section.

To increase the revenue of the *Journal*, each doctor present was asked to solicit advertising from firms in his locale. The question of advertising rates charged other medical groups in the state, such as specialty societies, was discussed. These groups have been paying a twelve-time rate for advertisements; it was recommended that in the future they be charged only the actual cost of printing the ad.

Dr. Woody expressed the hope that the *Journal* in the near future will be able to pay for a nominal number of illustrations for scientific articles. The number agreed upon as a reasonable one was three. At present the author is responsible for all expenses incurred in the publication of cuts in a scientific article. This change of policy is contingent upon the *Journal's* expenses being lowered or the income raised.

Each feature page of the *Journal* was discussed and reevaluated: the Heart Page and the Cancer Page should be limited to one page and not be

allowed to cover two or more pages as has been the case in some past issues; in the future any physician desiring to have his name published in the Doctor Placement lists more than three months will be required to pay for each insertion after the third insertion; the section, "Abstracts by Georgia Authors," should carry not more than one abstract by an author in a given month. All the other feature pages were thought to be acceptable as they are.

Ted F. Leigh asked the board members what they thought of having an interview feature (using as a model the interview with Dean R. Hugh Wood in the September Emory issue). The matter was discussed, and it was concluded that there is now a sufficient number of monthly features, and that such interviews would be desirable to clarify an issue, but not as an additional regular feature. Dr. Woody mentioned that the possibility of being able to publish Clinical Pathological Conferences was very real; it should materialize early in 1955.

Mr. John Stuart McKenzie, *Journal* typography consultant, asked for suggestions on the new cover design. He also made recommendations for improvements in typography within the *Journal*. This matter was referred to the staff for further study.

There being no further business, the meeting was adjourned at 6:00 p.m.

Preplanning Meeting

Committee on Public Health

Atlanta, October 27, 1954

A PREPLANNING meeting of the 1954-55 Committee on Public Health was called to order at 3 p.m., October 27, 1954, at the Academy of Medicine, Atlanta, by Chairman T. A. Sappington.

Present, in addition to Chairman Sappington, were T. F. Sellers, John Venable, Guy V. Rice, S. C. Rutland, Lester Petrie, R. C. Williams and Messrs. Milton D. Krueger and John F. Kiser, MAG Headquarters Office.

The minutes of the last two meetings of the committee were read and approved.

Mr. Krueger presented an organizational plan whereby the MAG Public Health Committee

would consider all matters of public health and function largely as a screening body; and, when matters referred to them involved other MAG Committees, this material would be turned over to the MAG Committee involved.

This plan then called for the MAG Public Health Committee to screen material for the following other MAG committees: Rural Health, Hospital, Industrial Health, Mental Health, Maternal and Infant Welfare, Chronic Illness, Liaison Advisory Board on Crippled Children, Legislation and Medical Civil Preparedness.

It was further recommended and approved that the chairmen of these committees by and large

compose the membership of the Public Health Committee.

It was also recommended and approved that each of these chairmen meet with members of the Department of Public Health within 60 days to effect better liaison and to receive background material on the projects and planning of the State Department of Public Health. Dr. Sappington discussed the idea that at some future date the MAG Constitution and By-Laws be changed to make the chairmen of the nine committees mentioned above active members of the Public Health Committee and to make these same nine committees subcommittees of the Public Health Committee. In that way, it was thought that better inner committee liaison may be effected and the MAG relationship with the State Department of Public Health be improved.

Dr. Sellers heartily endorsed this proposed organization and thought it also would improve the projects and planning of the committees involved.

Dr. Sappington moved that the chairmen of these nine committees be requested to attend the next meeting of the Public Health Committee.

Reports were received for the information of the Public Health Committee.

Dr. Rutland discussed the district plan for extension of local health services. This information was referred to the Rural Health Committee.

Dr. Rutland discussed dental care through local health departments, and this information was also referred to the Rural Health Committee.

Dr. Petrie discussed the program of home treatment of tuberculosis and the new commitment law for tuberculosis. This report was referred to the Rural Health Committee and the Industrial Health Committee.

Dr. Petrie discussed the State VD program which he said is at present inadequate because of reduction of federal funds. This information was referred to the Rural Health Committee and Industrial Health Committee.

Dr. Rice presented a map showing the location of child guidance centers in the State. This information was referred to the Mental Health Committee.

Dr. Rice discussed the crippled childrens program and his report was referred to the Liaison Advisory Board to the Georgia Society for Crippled Children.

Dr. Venable discussed appropriations needed to supply immediate needs. He stated that \$1,-020,000.00 are needed above presently available funds. His report was referred to the Committee on Legislation.

Dr. Williams discussed the medical facilities act of 1954 which will provide \$579,000 for Georgia for the construction of chronic disease hospitals, nursing homes, rehabilitation centers and diagnostic and treatment centers. This information was referred to the Committee on Hospitals.

Dr. Petrie presented a progress report on Civil Defense which was referred to the Committee on Medical Civil Preparedness.

Dr. Sellers discussed the home safety program sponsored by the Kellogg Foundation and asked for MAG endorsement. This information was referred to the next meeting of the Council of the MAG.

Dr. Sappington announced that the next meeting of the committee and chairmen of related committees will be held at 2 p.m., January 9, 1955, at the Regional Health Auditorium in Macon, Georgia.

Anesthetic Study Commission

DURING THE past year an Anesthetic Study Commission for the State of Georgia has been activated. Its function received the official sanction of the Medical Association of Georgia at the Annual Session in May 1954. The first meeting of the commission was held in Atlanta on September 19. This article has been prepared at the suggestion and through the cooperation of the members present at that meeting. It is designed to outline the function of this commission

and to serve as a reference for those who submit data to this group for study. Though this article appears under the by-line of the present chairman, due credit is hereby given to the other members for their aid in preparing this presentation.

Organization

The Anesthetic Study Commission consists of 12 members, selected for their interest in the problems involved. The members are listed here so that you may better understand the organization

of this group. With the exception of the Chairman, Lester Rumble, Jr. and Vice-chairman, A. J. Waters, one member is selected from each medical district. They are as follows: First District—Richardson L. Stone, Second District—P. D. Conger, Third District—P. G. Busby, Fourth District—Enrique Montero, Fifth District—Richard H. Smoot, Sixth District—Lee Fry, Seventh District—E. W. Culbreth, Eighth District—Ansley Seaman, Ninth District—G. H. Perrow and Tenth District—Edwin L. Rushia.

Purpose

The primary purpose of this group is to collect information regarding all deaths that occur during surgery or within 48 hours thereof. This information is then used to classify the death as to its probable cause, according to the classifications outlined below. By carrying out this function, certain "patterns" will undoubtedly develop which will make it possible for this group to make recommendations for reducing the mortality rate due to anesthesia. Let us stress that this information is gathered in such a manner that no one knows the identity of the hospital, surgeon, patient or anesthetist.

Modus Operandi

Each month the vice-chairman receives from the State Department of Public Health photostatic copies of each death certificate that falls within our category. He assigns a case number to this certificate and forwards a blank protocol bearing this number to the administrator of the hospital in which the death occurred. With this protocol, which is two pages in length, goes a letter bearing the patient's name, date of demise and the request that the enclosed form be given to the anesthetist and/or surgeon. Enclosed also is a stamped, self-addressed envelope for the return of the completed forms to the chairman. Upon receipt of the completed form, the chairman notifies the vice-chairman that case number "5-19" has been received and the copy of the death certificate is destroyed. A new number is assigned to the case, thus making it impossible to identify any party associated with the event. In addition to the protocol, a copy of the anesthetic record is requested.

Classification of Deaths

At its first meeting the commission set up the following outline to serve as a basis for classifying the deaths that occur within the period in which it is interested. It is felt that this outline will also serve to cover all surgical mortalities if the functions of this commission are enlarged at a later

date. Careful consideration of this outline should make possible the more complete and intelligent completion of the Study Commission forms.

I. Error in Surgical Judgment:

- a. Technical (ex: laceration of portal vein during cholecystectomy)
- b. Diagnostic (ex: acute appendicitis operated upon when actual diagnosis is lobar pneumonia)
- c. Management (ex: lack of proper fluid balance, dehydration, non-correction of anemia before surgery)

II. Pre-existing Disease:

- a. Primary (ex: mesenteric thrombosis, malignant disease, extreme trauma)
- b. Calculated Risk (ex: necessary surgery in patient with recent coronary thrombosis)

III. Anesthesia:

- a. Pre-operative Error (ex: lack of atropine, full stomach, etc.)
- b. Improper choice of agents or techniques (ex: giving own spinal without proper supervision of patient, using adrenalin with cyclopropane)
- c. Errors in management:
 1. Overdosage of agent or drug
 2. Inherent toxicity of agent or drug
 3. Failure to maintain patent airway
 4. Aspiration without proper therapy
 5. Inadequate or improper fluid replacement
 6. Faulty positioning
 7. Explosion
 8. Technical misuse of gas machine
 9. Error in technique (ex: intra-vascular injection of Novocaine)
 10. Transfusion reaction
- d. Errors in resuscitation (ex: injection of adrenalin into the heart rather than opening the chest in cardiac arrest)
- e. Improper post-anesthetic supervision

IV. Cases in which evidence submitted is insufficient to warrant discussion and does not permit classification.

We realize that many times the circumstances that exist in the location where the case is done do not permit a wide choice of anesthetic agents and techniques. However, all causes of death will carry the notation of preventable or non-preventable, not from the standpoint of circumstances, but from the standpoint of its part in the cause of death. Where there are two or three con-

tributing factors responsible for the patient's demise, one will be listed as primary and the others as contributory causes.

Report of First Meeting

The first order of business was to acquaint the members with the *modus operandi* of the commission. The plan, with one addition, was unanimously approved. Since only about 50 per cent of the protocols had been returned, it became obvious that some method is needed for reminding the individuals concerned when the protocol has not been received. It was agreed that the vice-chairman will send at the end of each month a double post-card to the hospitals from which the forms have not been received. The card will contain the second request for the return of the completed forms. The return card will give the recipient a means whereby new forms may be requested in the event that the original ones have been mislaid. At the same time, the member of the commission from the district in which that hospital lies, will receive a list of the delinquent cases. He will then contact the administrator by phone or mail in order to encourage the completion and return of the forms. We are pleased that as many as 50 per cent of these cases have been completed, but we shall continue to hope for 100 per cent returns.

The second matter discussed was the possibility of holding a meeting of the commission in conjunction with one district meeting each month. It was felt that benefit would be obtained from discussing some of the unusual cases with a view toward improving anesthetic management. The commission member from each district will be in charge of such a program which will take place once a year in each district. Further plans of this nature will be announced.

The third consideration was that of the best avenue for disseminating the findings of the commission so that the information will be of value to the medical profession of the entire state. After discussing separate publications, monthly newsletters, etc., it was decided that the *Journal of the Medical Association of Georgia* would be the best means for this purpose. In the future, separate publication may be feasible if the volume of cases increases.

Lastly, the members spent several hours in discussing the 17 cases which had been received by that date. The cause of death was classified as follows:

Error in Surgical Judgment	Technical	2	Preventable
Error in Anesthetic Management	Misuse of Machine	1	Preventable
Pre-Existing Disease	Primary	6	Non-preventable
Pre-Existing Disease	Calculated Risk	1	Non-preventable
Error in Surgical Judgment	Diagnosis	1	Preventable
Error in Anesthetic Management	Resuscitation	1	Preventable
Insufficient Data		5	

Comments

In reading the completed protocols many omissions of pertinent data were encountered. As noted above, many cases had to be placed in the category of "incomplete data." The remainder of this article contains suggestions for rectifying some of these errors.

The most outstanding factor that is amenable to immediate correction is the lack of anesthetic records. At least 50 per cent of the protocols were returned without any sort of record of the anesthetic. Some bore the notation "no anesthetic record kept." To us, the failure to keep an anesthetic record is "prima facie" evidence that the best possible anesthetic administration is not being rendered to that patient. Certainly, no one would state that in a given case the keeping of such a record would make a "life and death" difference to the patient. However, the act of recording events as they take place tends to keep one on his toes, and over a period of many administrations may serve to be actually life saving. The record's constant reminder that blood pressure, pulse and respiration must be checked keeps the anesthetist from falling asleep with the patient. No one, be he doctor, nurse or technician should fail to keep a current record of the events which take place during the course of even the simplest anesthetic.

What should a basic record contain? We will list the items for the sake of brevity.

1. The dosage, route of administration and time of premedicant drugs.
2. The amounts, concentrations and technique of administration of the anesthetic drugs.
3. The time of the start and finish of anesthesia and surgery, including the time of intubation.
4. The amounts, route of administration and time of any adjuvant drugs, such as curare, ephe-drine, etc.

5. A recorded blood pressure, pulse rate and respiratory rate at intervals of no less than 15 minutes.

6. Notations as to the "apparent" cause of any aberrations in the above.

7. The types and amounts of intravenous fluids, blood or blood substitutes.

8. The degree of return of reflex activity when the patient is returned to bed.

Failure to keep an anesthetic record in the light of present day methods and practices is considered medical malpractice.

The second neglected portion of the protocol is in the section which describes the operative findings. In future printings more space will be allotted to this section. In the interim we urge that the margin or an additional sheet be utilized. Without an adequate (not necessarily lengthy) report of the findings at surgery, it is virtually impossible to assign the death to its proper category.

In some instances, no urinalysis or blood count was recorded. If surgery of any sort is to be accomplished intelligently, there are several "routine" studies which are essential. No patient should be placed on the operating table (except in extreme emergency) unless a physical examination including temperature, blood pressure, pulse rate and heart and lung check has been performed. A CBC and urinalysis should be on record. The failure of these items to appear on the protocols indicates that many patients are being subjected to anesthesia without proper preparation. In two instances the only words appearing under the pre-operative condition section were "the patient was in poor shape." This does not give any real

information about the case, and to us indicates a rather "poor" approach to any surgical problem.

It is not the desire of the commission that extremes in detail be submitted. However, we do urge that essential information not be omitted, since this omission renders the protocol valueless. No one group should receive so many requests for this information that the load of completing the questionnaires would become a burden.

The last matter which warrants discussion is the low incidence of post mortem examinations in this group of patients. To add insult to injury, several protocols contained the notation "no post mortem obtained since it would have cost the family \$50.00, and they could not afford it." The value received from post mortem study in these instances, where the cause of death is many times open to speculation, makes it imperative that as much effort as possible be expended to obtain such an examination. Certainly the placing of a charge to the family for such an examination is most difficult to understand. Some consideration should be given to legislation that would provide mandatory post mortem examination in all deaths that occur in the operating room or within 72 hours of surgery.

The success or failure of the commission lies in the hands of those who receive its requests for information. We have endeavoured to make this as simple and impersonal as possible. If you have any suggestions for improving this method of collecting such vital information, do not hesitate to let us know them.

*Lester Rumble, Jr., M.D.
Chairman*

Industrial Health Congress to Meet in January

Building an effective health program for American industry utilizing the facilities of medicine, government, management and labor will be emphasized at the 15th Annual Congress on Industrial Health. Sponsored by AMA's Council on Industrial Health, the Congress will be held January 25 and 26 at the Shoreham hotel, Washington, D. C.

Following the general theme—"Goals of Preventive Medicine"—panel discussions will be presented on: (1) Industrial health as a major com-

ponent in community health; (2) Training and recruitment of qualified professional personnel; (3) Medical care plans; (4) Workmen's compensation and rehabilitation, and (5) Health in the atomic age, stressing the need for modern protective methods of safeguarding the worker's health.

A pre-conference session for medical society committee members will be held January 24 to consider problems of special interest to the medical profession.

ANNOUNCEMENTS

South Atlantic Association of Obstetricians and Gynecologists—Williamsburg, Va., February 10, 11 and 12, 1955. For information write to Dr. C. H. Mauzy, Secretary-Treasurer, Bowman-Gray School of Medicine, Winston-Salem, N. C.

Georgia Society of Ophthalmology and Otolaryngology—General Oglethorpe Hotel, Savannah, Ga., March 11-12, 1955. Speakers will be: Dr. Francis H. Adler, Philadelphia; Dr. J. W. McCall, Cleveland; Dr. J. A. Hilger, St. Paul; Dr. Walter H. Fink, Minneapolis; Dr. James H. Allen, New Orleans; and Dr. P. E. Ireland, Toronto. For further information contact Dr. Alton V. Hallum, 490 Peachtree St. N.E., Atlanta, Ga.

Seventh Annual Convention International Academy of Proctology—Plaza Hotel, New York City, March 23 to 26, 1955. All physicians and their wives are cordially invited. For information write to the International Academy of Proctology, 147-41 Sanford Ave., Flushing, New York.

Sixth Congress Pan-American Academy of General Practice—Lima, Peru, February 11 to 25, 1955. The number of invitations is limited. Application should be made to Arturo Martinez, M.D., Secretary, Pan-American Academy of General Practice, 54 East 72nd Street, New York 21, N. Y.

Atlantic City Meeting, American Medical Association—June 6-10, 1955. Deadline for Scientific Exhibits is January 10, 1955. Applicants should communicate with the Secretary of the Scientific Exhibits of the section in which they are interested. Further information may be obtained from the Secretary, Council on Scientific Assembly, AMA, 535 North Dearborn St., Chicago 10, Illinois.

Association of American Physicians and Surgeons, Inc. has moved its headquarters from 360

North Michigan Ave. to 185 North Wabash Ave., Suite 318, Chicago 1, Illinois.

Alumni Postgraduate Convention, College of Medical Evangelists—Biltmore Hotel, Los Angeles, California, February 15 to 17, 1955. For further information address the Managing Director, Walter B. Crawford, 316 North Bailey St., Los Angeles 33, California. This convention is open to all physicians.

International Academy of Proctology—Annual Cash Prize Certificate of Merit Award Contest for 1954-1955. All entries must be received no later than February 1, 1955; the competition is open to all physicians. For further information write to the International Academy of Proctology, 147-41 Sanford Avenue, Flushing 55, N. Y.

U. S. Public Health Service—Competitive examination for appointment of medical officers will be held on February 15, 16 and 17, 1955. For application forms write to the Chief, Division of Personnel, Public Health Service, Dept. of Health Education and Welfare, Washington 25, D. C. These forms must be submitted no later than January 12, 1955.

American Board of Physical Medicine and Rehabilitation—The next examinations for the American Board of Physical Medicine and Rehabilitation will be held in Philadelphia, June 5 and 6, 1955. Applications must be filed by March 1, 1955. Address the Secretary, Dr. Earl C. Elkins, 30 N. Michigan Ave., Chicago 2, Ill.

Van Meter Prize Award—The American Goiter Association offers \$300.00 and two honorable mentions for the best essays submitted concerning original work on problems related to the thyroid gland. The award will be made in April 1955; entrance deadline is January 15, 1955. For further information write to the Secretary, John S. McClintock, M.D., 149½ Washington Ave., Albany, N. Y.

DEATHS

JOHN REID BRODERICK, Savannah, 56, died November 7, 1954, after an illness of several weeks. Dr. Broderick was a native of Savannah; he was

educated in the public schools there, Georgetown University and Jefferson Medical College, Philadelphia. A member of Sacred Heart Roman Catholic Church, he took an active interest in church affairs. He was a past president of the Catholic Laymen's Association of Georgia, a mem-

ber of the Fourth Degree Assembly of the Knights of Columbus and of the Holy Name Society of Sacred Heart Church.

Dr. Broderick was chairman of the board of governors, chief of services and past president of the staff of St. Joseph's Hospital. He was, in addition, on the staffs of the Telfair, Warren Candler and the Central of Georgia Hospitals. He had only recently been appointed to the staff of the Chatham County Memorial Hospital.

A member and past president of the Georgia Medical Society, Dr. Broderick was also a fellow of the American College of Physicians and a fellow of the Academy International of Medicine. He was vice-president of the Hibernian Society, a member of the Rotary Club, the Oglethorpe

Club and the Savannah Yacht and Country Club. He was a former member of the Chatham County Board of Education and served a term as member of the Board of Sanitary Commissioners.

Funeral services were held November 9th at his home with burial in the Holy Cross section of the Catholic Cemetery. Members of the Georgia Medical Society were honorary pallbearers.

"Dr. Broderick gave of himself to his patients, going at any hour to ease them through crises and, with a deep and abiding interest in their welfare, counseling them whenever he saw those who had entrusted themselves to his care. Their numbers are many, and each of them, mourning his passing, will recall him as a fine physician and a true friend." (*Savannah Press*)

SOCIETIES

The FIFTH DISTRICT MEDICAL SOCIETY and the WOMAN'S AUXILIARY TO THE FIFTH DISTRICT MEDICAL SOCIETY met for dinner November 4, 1954, at the Academy of Medicine, Atlanta. Mr. Leo Aikman, of the Atlanta Constitution, was guest speaker, and Mrs. Thomas Guffin presented a musical program. Mrs. Chris McLoughlin, manager of the auxiliary, presided.

The THIRD DISTRICT MEDICAL SOCIETY met November 18, 1954, at the Americus Country Club. J. C. Logan, Plains, gave the Invocation; A. C. Primrose, Americus, the Address of Welcome; and Robert H. Vaughan, Columbus, responded to the Address of Welcome. The participating in the Scientific Program were as follows: John K. Davidson, Columbus, "Clinical Use of Anticoagulants"; Richard Torpin, Augusta, "Vaginal Hysterectomy"; John H. Robinson III, Americus, "Carcinoma of the Breast"; C. H. Heuser, Augusta, "Twinning"; Edgar Pund, Augusta, "Projected Policies of the Eugene Talmadge Memorial Hospital"; and W. P. Jordan, Sr., "Some Common Urological Problems."

At the business session the following officers were elected: John L. Stapleton, president; John L. Gallemore, vice-president; and Schley Gatewood, secretary. W. G. Elliott was nominated for the office of councilor, and Luther Wolfe, for the office of vice-councilor.

GEORGIA MEDICAL SOCIETY met November 9, 1954, at the Society's Hall, 612 Drayton Street,

Savannah. Howard J. Morrison, Chairman of the By-Laws Committee, presented for approval the changes and modifications of the Constitution and By-Laws of the society which are routinely modified every five years.

Members of the DEKALB COUNTY MEDICAL SOCIETY entertained their wives at a dinner party on Wednesday, November 10, 1954, at East Lake Country Club, Atlanta. Dr. and Mrs. Robert Shinall and Dr. and Mrs. Howard Lee were in charge of arrangements.

LAURENS COUNTY MEDICAL SOCIETY held a dinner meeting on October 14, 1954. The program was presented by Edwin Watson and Howard Williams, Macon pediatricians.

The SOUTH GEORGIA MEDICAL SOCIETY met in November in Valdosta. The main item of business discussed was the resolution to do away with the baseball park immediately adjacent to the New County Hospital, Valdosta. The society unanimously approved this resolution calling for the removal of the baseball park before the new hospital is opened.

WARE COUNTY MEDICAL SOCIETY met recently at the Golf Club in Waycross. J. L. Alexander, Savannah, spoke on "Suppurative Diseases of the Lung." Dr. Alexander discussed the three major types of lung abscesses: bronchiectasis, empyema of the chest and common lung abscesses. Following Dr. Alexander's talk letters to the society expressing approval of the public service rendered by Ware County doctors in presentation of medical forums were read.

The SIXTH DISTRICT MEDICAL SOCIETY met December 1, 1954, in Macon with Bibb County Medical Society acting as hosts. George H. Alexander, Forsyth, is president of the Sixth District; C. L. Ridley, Jr., Macon, vice-president; C. H. Richardson, Jr., Macon, secretary-treasurer. Those appearing on the scientific program were Braswell Collins, Macon, "E.E.N.T. Causes of Head-

ache"; Edgar Fincher, Emory University, "Diagnosis of Brain Tumors"; J. P. Woodhall, Macon, "Cancer of the Lung in Central Georgia"; and Hugh Sealy, Macon, "Coronary Artery Disease." Following the business meeting a social hour and dinner were held at the American Legion Club, Riverside Drive, Macon.

PERSONALS

EDWIN W. ALLEN, Milledgeville, was named vice-president of the Southern Psychiatric Association at the meeting of the association in Louisville in October.

Four Emory University research projects are among those listed in the annual report of the board of directors of the Life Insurance Medical Research Fund. H. D. Bruner is making a study designed to measure the extent and significance of the lymphatic outflow from the kidney; Eugene B. Ferris, Jr., is studying the course of a group of hypertensive patients with reference to severity of the disease; A. E. Wilhelmi is working with insulin and anti-insulin factors in metabolism; and Eugene A. Stead, Jr., formerly with Emory and currently at Duke University, is doing research in cardiovascular and respiratory physiology.

ELEANOR F. BUNDY, Decatur, has moved her office into the new building at the corner of Church and Williams streets in Decatur.

LLOYD L. BURNS, Atlanta, has been named resident chief of obstetrics and gynecology at Crawford W. Long Memorial Hospital in Atlanta. Dr. Burns is the son of Dr. and Mrs. D. L. BURNS of Valdosta, and he is a graduate of Emory University School of Medicine.

WILLIAM C. CALHOUN, Waycross, has opened new offices at 703 Elizabeth Street. Dr. Calhoun, who specializes in surgery and obstetrics, is a former president of Ware County Medical Society. He is president of the medical staff of the Ware County Hospital. Dr. Calhoun is a native of Macon and a graduate of Mercer University and the Medical College of Georgia.

OLIN S. COFER, Atlanta, and Mrs. Cofer attended the recent meeting of the Southern Medical Association in St. Louis. Dr. Cofer, as council

chairman, gave the response to the address of welcome and presented the past president's medal to Alphonse McMahon on his retirement as president. Other Atlantans attending the meeting were Dr. and Mrs. TED F. LEIGH, Dr. and Mrs. MASON I. LOWANCE, Dr. and Mrs. AUGUST TURNER, Dr. and Mrs. SHELLEY DAVIS, ELISABETH MARTIN, Chairman of the Women Physicians of the Association, HARRIETT GILLETTE, Dr. and Mrs. JOHN MCCAIN, Dr. and Mrs. HUGH HAILEY, Dr. and Mrs. HAROLD P. McDONALD, WILLIAM W. BRYAN and LESTER RUMBLE, JR. The following Atlanta physicians read papers at the meeting: JOHN ATWATER, WILLIAM L. DOBES, J. D. MARTIN, JR., and WILLIAM A. SMITH.

In October JOHN A. CORRY, Barnesville, was honored at a special meeting of the Rotary Club. Dr. Corry was first president of the club and this surprise celebration, "Dr. Corry Night," assembled Past District Governors of Rotary and past presidents of the club, representatives from the MAG and a number of Rotarians and their wives from Griffin. Mr. Otis Blake of Griffin presented Dr. and Mrs. Corry with a beautiful silver bowl from the Griffin Rotary Club.

T. F. DAVENPORT, Atlanta, has been named head of the medical advisory board of the Fulton-DeKalb Chapter, Muscular Dystrophy Association of America, Inc. Other members of the board are J. H. KITE, HARRIETT GILLETTE, T. J. ANDERSON, PAUL L. SCHROEDER and CHARLES JENNINGS.

Joseph P. Doyle, Camilla, recently opened offices for the general practice of medicine in the Crovatt Building, 28 Court Street, Camilla. A native of East Prairie, Mo., Dr. Doyle is a graduate of Washington University Medical School, and for the past two years he has been in the Medical Corps of the U. S. Air Force stationed at Turner Field, Albany. There he served as chief of obstetrics and gynecology.

JOHN A. DUNCAN, Harlem, has recently returned to Harlem, and he has his offices at present at his home on Milledgeville Road.

Fletcher Woodward, of the University of Virginia Medical School, presented the Eighth Annual Jonte Equen Memorial Lecture on Thursday, November 11, 1954, at the Academy of Medicine, Atlanta. He spoke on "The Physician's Responsibility in the Prevention of Auto Injuries and Deaths." JACK C. NORRIS, Atlanta, is chairman of the Equen Memorial Lectureship which was established by MURDOCK EQUEN in 1936 in memory of his father, Jonte Equen.

ALBERT FISHER, Atlanta, announces the opening of his office in the Cyrus W. Strickler Sr. Doctors Building, Suite 521, for the practice of ophthalmology.

W. RALEIGH GARNER, Gainesville, was chairman of Diabetes Week in Hall County. Members of the Hall County Medical Society made tests for diabetes free of charge during Diabetes Week, November 14-20, as a service to the community.

BOLLING GAY, Atlanta, recently addressed the Moreland Parent-Teacher Association; his subject was "Health—Physical, Mental and Spiritual—Is Wealth; Invest in It."

L. H. GRIFFIN, Claxton, recently opened the Griffin Clinic, a 16-bed hospital in Claxton. Facilities include white and colored reception rooms, nursery, kitchens, separate operating and delivery rooms, X-ray, laboratory and examining rooms. Dr. Griffin is a graduate of the University of Georgia and the Medical College of Georgia. He has been in practice in Claxton since 1939 except for five years spent in the U. S. Army.

RONALD M. GUSTIN, Athens, announces the opening of his private offices in the Southern Mutual Building for the practice of medicine. Dr. Gustin is a graduate of the University of Tennessee and served as resident physician at St. Mary's Hospital, Athens.

WILLIAM D. JENNINGS, JR., Augusta, announces the opening of his office for the practice of general surgery, 806 Marion Building, Augusta.

FLEMING L. JOLLEY, Atlanta, announces the opening of his office at 715 Doctors Building, 478 Peachtree Street, N.E., Atlanta, for the practice of neurological surgery.

A. J. KRAVTIN, Columbus, spoke at a recent Hadassah meeting on the subject, "The Medical Situation Today."

E. M. LANCASTER, Shady Dale, is the first person in Jasper County to use the new automatic answering and recording equipment furnished by Southern Bell Telephone Co. The device enables Dr. Lancaster to advise calling parties where he may be reached and also to receive messages in his absence. The machine can record a maximum of 20 messages of 28 seconds duration.

LAWRENCE LEE, JR., Savannah, was chairman of the committee on diabetes of the Georgia Medical Society. As part of the program for Diabetes Week in Savannah, some 700 students at Savannah High School were tested for signs of the disease. Dr. Lee stressed the importance of early detection in children, and expressed the appreciation of the committee to school authorities for their help.

ROBERT MABON, Atlanta, was named to the executive committee of the Congress of Neurological Surgeons at its annual meeting in New York City.

L. T. MAHOLICK, Columbus, was guest speaker at a recent meeting of the Columbus Rotary Club. He is a graduate of the University of Maryland School of Medicine and has been associated with Emory University Hospital, Lawson General Veterans Hospital, Oliver General Army Hospital and was on the faculty of the Medical College of Georgia.

A medical forum was the program presented at the November meeting of the Woman's Auxiliary to the Fulton County Medical Society. The topic discussed was, "The Trouble with Women." Panel members were JOHN R. MCCAIN, Decatur, CHARLES UPSHAW, JOHN RIDLEY and MARION T. BENSON, all of Atlanta. Mrs. Shelley Davis, president of the Woman's Auxiliary to the Medical Association of Georgia was panel moderator.

HORACE LEE MORGAN, formerly of Colquitt, has recently moved to Arlington where he has an office in the City Hospital. Dr. Morgan is a graduate of Duke University Medical School; he interned at Grady Memorial Hospital in Atlanta and has practiced in Bogalusa, La., and Colquitt.

HOWARD J. MORRISON, Savannah, and S. FARNUM COFFIN, formerly of Boston, Mass., announce their association for the practice of pediatrics at 444 Drayton Street, Savannah.

L. K. NEWLIN, formerly of Columbus, has moved to Valdosta and opened offices at 1802 North Ashley Street for the practice of pediatrics.

JESSE L. PARROTT, Hahira, was guest speaker at the November meeting of the Math-Science Club at Valdosta State College. The history of medicine was the theme of Dr. Parrott's talk; he gave a brief summary of the different stages of medical advancement. Dr. Parrott has recently been elected mayor of Hahira, and he is president of the South Georgia Medical Society.

E. V. PATRICK, Carrollton, has been elected chief of staff of the Tanner Memorial Hospital in Carrollton. Other officers include STEVE WORTHY, vice-chief of staff, and FRANCES PARKS, secretary and treasurer. The following physicians were elected to serve as chiefs of services: surgery, O. W. ROBERTS; medicine, E. W. THOMASSON; obstetrics, STEVE WORTHY; eye, ear, nose and throat, D. S. REESE; scientific services, FRANCIS PARKS; and dental services, SELBY CRAMER.

T. A. PETERSON, Savannah, took office in November as president of the Association of Seaboard Air Line Railway Surgeons, according to an announcement from J. W. PALMER, secretary and treasurer of the association. Other Savannah physicians on the Seaboard staff who attended the convention in November were JABEZ JONES, J. K. QUATTLEBAUM, R. L. NEVILLE, W. D. WILSON, JOHN W. DANIEL, JR., JULIAN F. CHISHOLM and ST. JULIAN DECARADEUC.

QUENTON RANDOLPH, Winder, was recently

commissioned a lieutenant in the U. S. Navy Medical Corps and he has reported for active duty in Charleston, S. C.

A. A. ROGERS, Commerce, has been reelected chairman of the board of deacons of the First Baptist Church of Commerce. PAUL T. SCOGGINS is also a member of the board.

PAUL T. RUSSELL, Albany, announces the opening of his offices in the Doctors Center, 1009 North Monroe, for the practice of medicine and surgery.

H. F. SHARPLEY, JR., Savannah, company surgeon for the Central of Georgia Railway, has been made a member of the company's Quarter Century Service Club.

ABRAHAM S. VELKOFF, Atlanta, announces the association of HERBERT L. SHESSEL for the practice of obstetrics and gynecology in new offices at 1293 Peachtree Street, N.E., Atlanta.

J. L. WALKER, Clarkesville, participated in a panel discussion on local health problems at the November P.-T.A. meeting in Clarkesville.

RICHARD K. WINSTON, Valdosta, at a recent meeting of the United Daughters of the Confederacy spoke of the work of surgeons and physicians during the War Between the States, and the handicaps and hardships they endured.

D. LLOYD WOOD, Dalton, spoke to a recent meeting of the Dalton Rotary Club on the symptoms and treatment of cancer.

Action by Committee on Toxicology

AMA's new Committee on Toxicology now is studying ways of halting the spread of accidental poisonings through misuse of common household chemicals such as drugs, cosmetics, cleaning fluids, paints. A recent exploratory meeting drew representatives from medicine, government and industry to Chicago Headquarters to spearhead plans for a concerted campaign in this direction.

The Committee's current progress report shows that it has collaborated with various national organizations interested in these problems; is rep-

resented on the American Standard Association sectional committee studying hazards to children and on the board of the Chicago Poisoning Control Center. In addition, it has offered advice for the standardization of safe coatings for children's toys and furniture; made suggestions on New York City's sanitary code relative to the labeling of lead paints; reviewed a section on antidotes for the National Formulary, and participated in the revision of "Official Antidotes" of the California State Board of Pharmacy.

Amebiasis¹ a "Poorly Reported" Disease

*Until serious complications arise,
amebiasis may pass unrecognized and
patients receive only symptomatic treatment.*

Although amebiasis is a disease with serious morbidity and mortality, statistics on its incidence¹ are incomplete because its manifestations are not commonly recognized and consequently not reported.

"Vague symptoms² referable to the gastrointestinal tract, such as indigestion or indefinite abdominal pains, with or without abnormally formed stools, may result from intestinal amebiasis. Not infrequently in cases in which such symptoms are ascribed to psychoneurosis after extensive x-ray studies have been carried out, complete relief is obtained with antiamebic therapy."

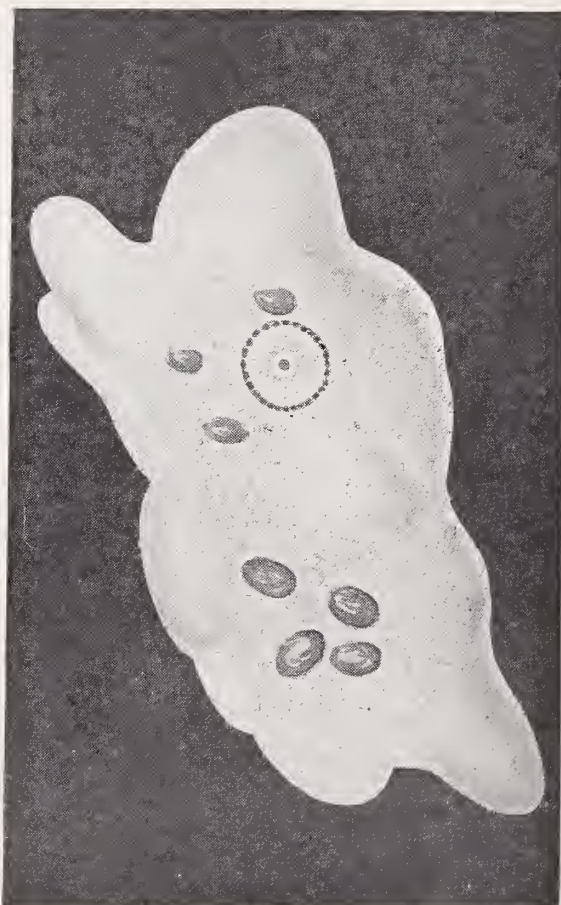
To prevent possible development of an incapacitating or even fatal illness and to eliminate a reservoir of infection in the community, diagnosing and treating³ even seemingly healthy "carriers" and those having mild symptoms of amebiasis is advised.

Early diagnosis¹ is important because infection can be rapidly and completely cleared, with the proper choice of drugs and due consideration for the principles of therapy. For treatment of the bowel phase these authors find Diodoquin "most satisfactory."

For chronic amebic infections, Goodwin⁴ finds Diodoquin to be one of the best drugs at present available.

Diodoquin, which does not inconvenience the patient or interfere with his normal activities, may be used in the treatment of acute or latent forms of amebiasis. If extraintestinal lesions require the use of emetine, Diodoquin may be administered concurrently. It is a well tolerated and relatively nontoxic orally administered amebicide, containing 63.9 per cent of iodine.

Diodoquin (diiodohydroxyquinoline), available in 10-grain (650 mg.) tablets, reduces the course of treatment to twenty days (three tablets daily). Treatment may be repeated or prolonged without



Endamoeba histolytica (trophozoite).

serious toxic effect. It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. G. D. Searle & Co., Research in the Service of Medicine.

1. Hamilton, H. E., and Zavala, D. C.: Amebiasis in Iowa: Diagnosis and Treatment, *J. Iowa M. Soc.* 42:1 (Jan.) 1952.

2. Goldman, M. J.: Less Commonly Recognized Clinical Features of Amebiasis, *California Med.* 76:266 (April) 1952.

3. Weingarten, M., and Herzig, W. F.: The Clinical Manifestations of Chronic Amebiasis, *Rev. Gastroenterol.* 20:667 (Sept.) 1953.

4. Goodwin, L. G.: Review Article: The Chemotherapy of Tropical Disease: Part I. Protozoal Infections, *J. Pharm. & Pharmacol.* 4:153 (March) 1952.

CLASSIFIED ADVERTISING

FOR SALE: Well established E. E. N. T. practice for sale in progressive city, Columbus, Muscogee County, Georgia. Excellent equipment and opportunity. Write M. C. W.H., c/o The JOURNAL of the MAG.

FOR RENT: Doctors office in West Peachtree Doctors' Building, 663 W. Peachtree St., Atlanta, for rent January 1, 1955. Recently redecorated, wall-to-wall carpeting, air conditioned, excellent location, 750 square feet, \$150.00 per month, parking available in rear of building. For information call EMerson 1717 or EMerson 2341.

FOR SALE: Folding wheelchair, purchased new, unused. Original price \$65.00. Asking \$45.00. T. L. Hodges, Jr., M.D., Piedmont Hospital, Atlanta.

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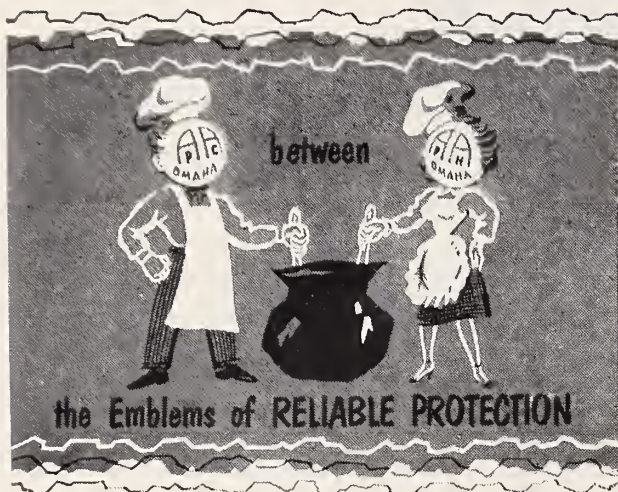
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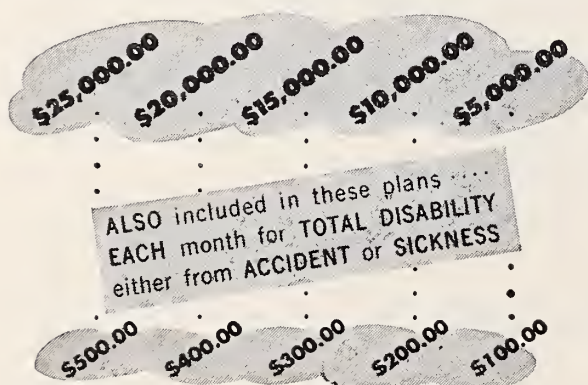
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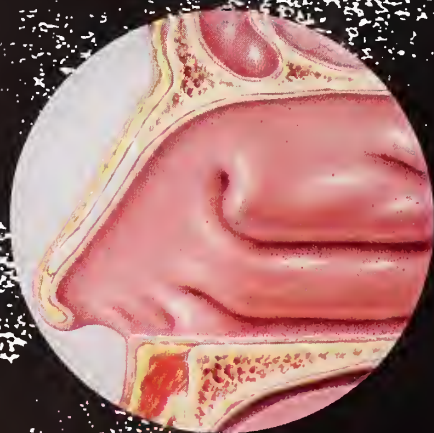
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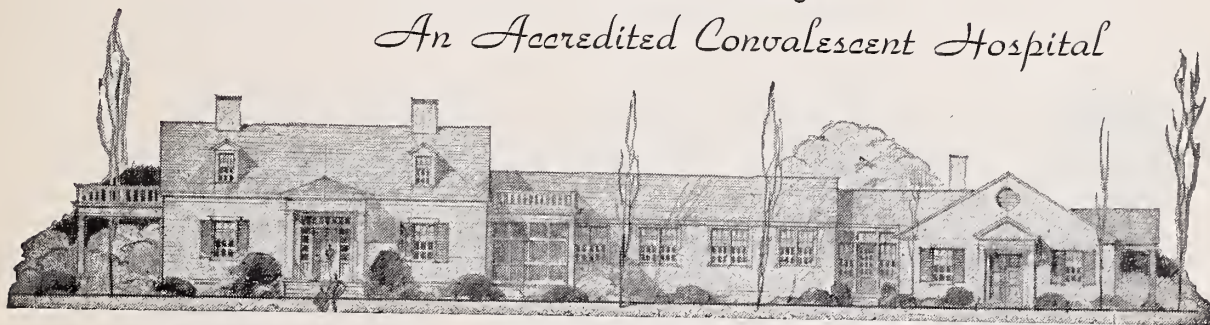
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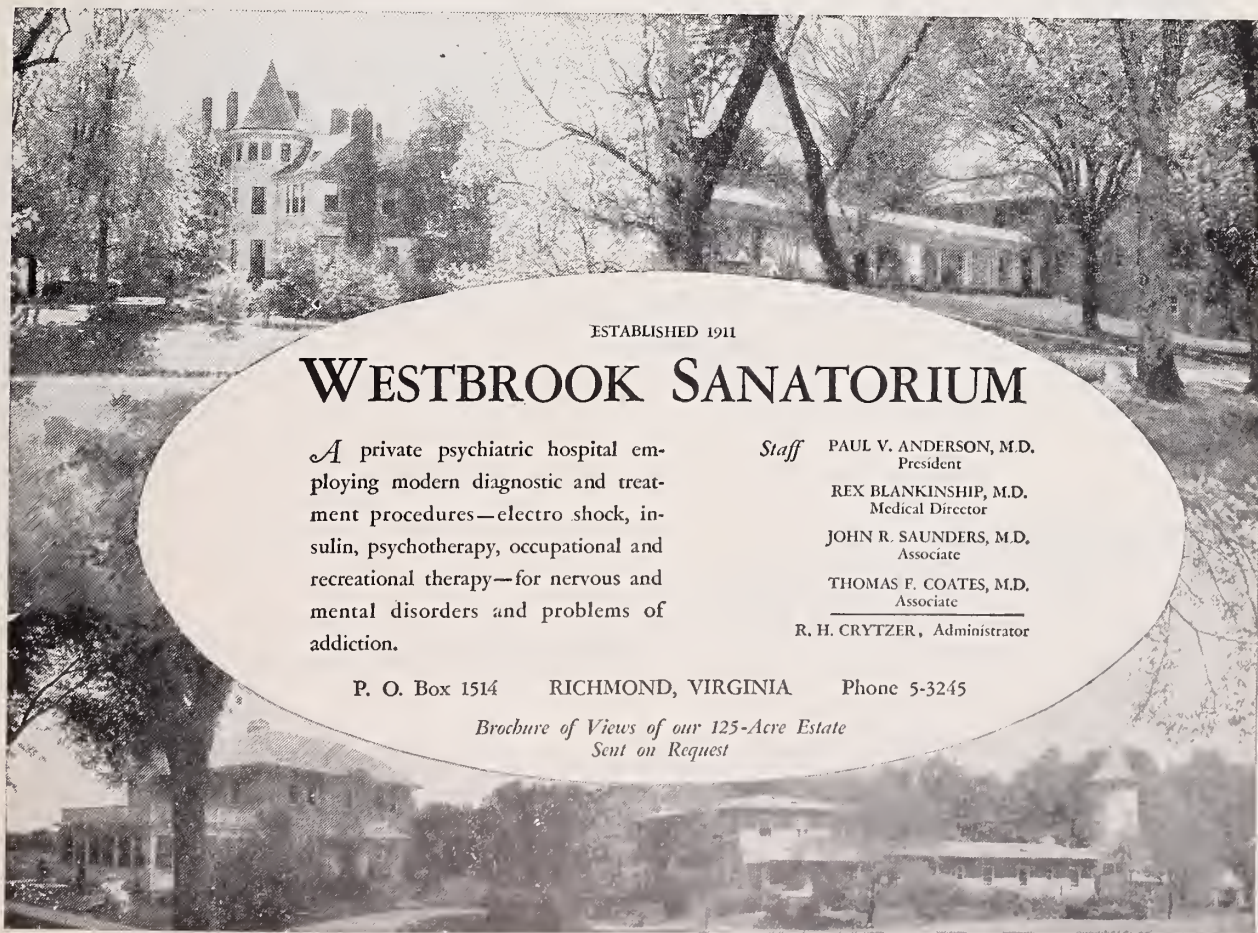
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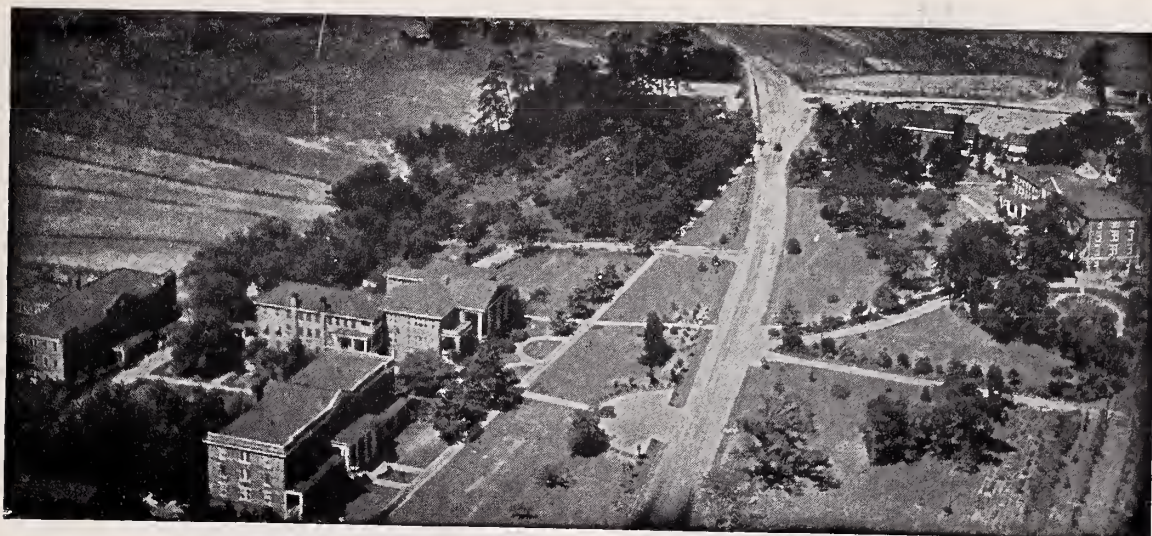
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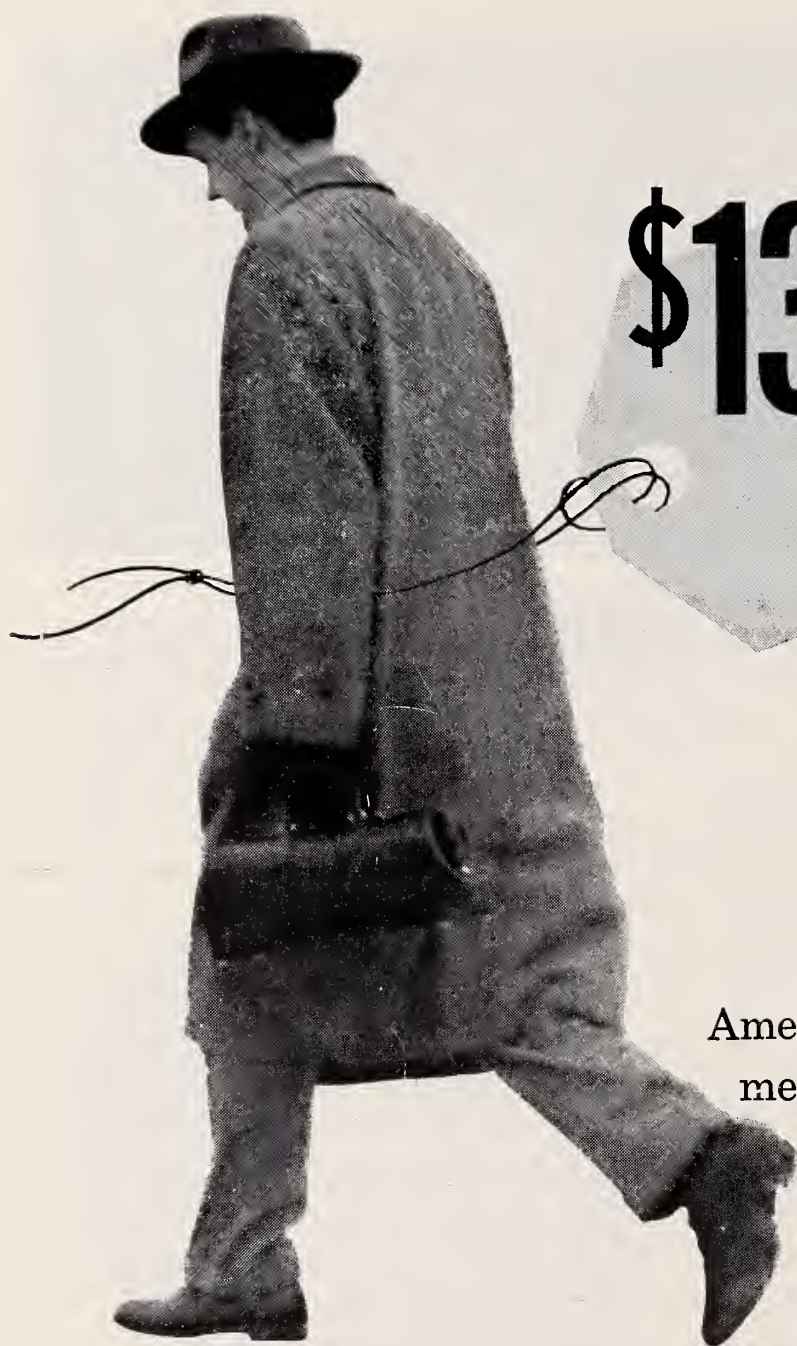


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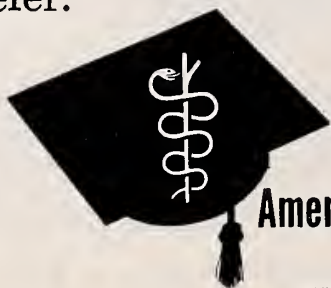
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1. Malleson, J.: *Lancet* 2:158 (July 25) 1953. 2. Goldzieher, M. A., and Goldzieher, J. W.: *Endocrine Treatment in General Practice*, New York, Springer Publishing Company, Inc. 1953, p. 23.

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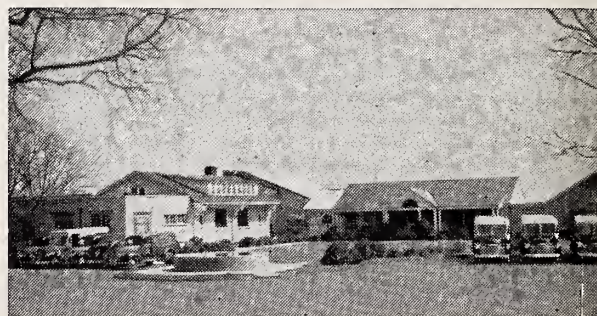
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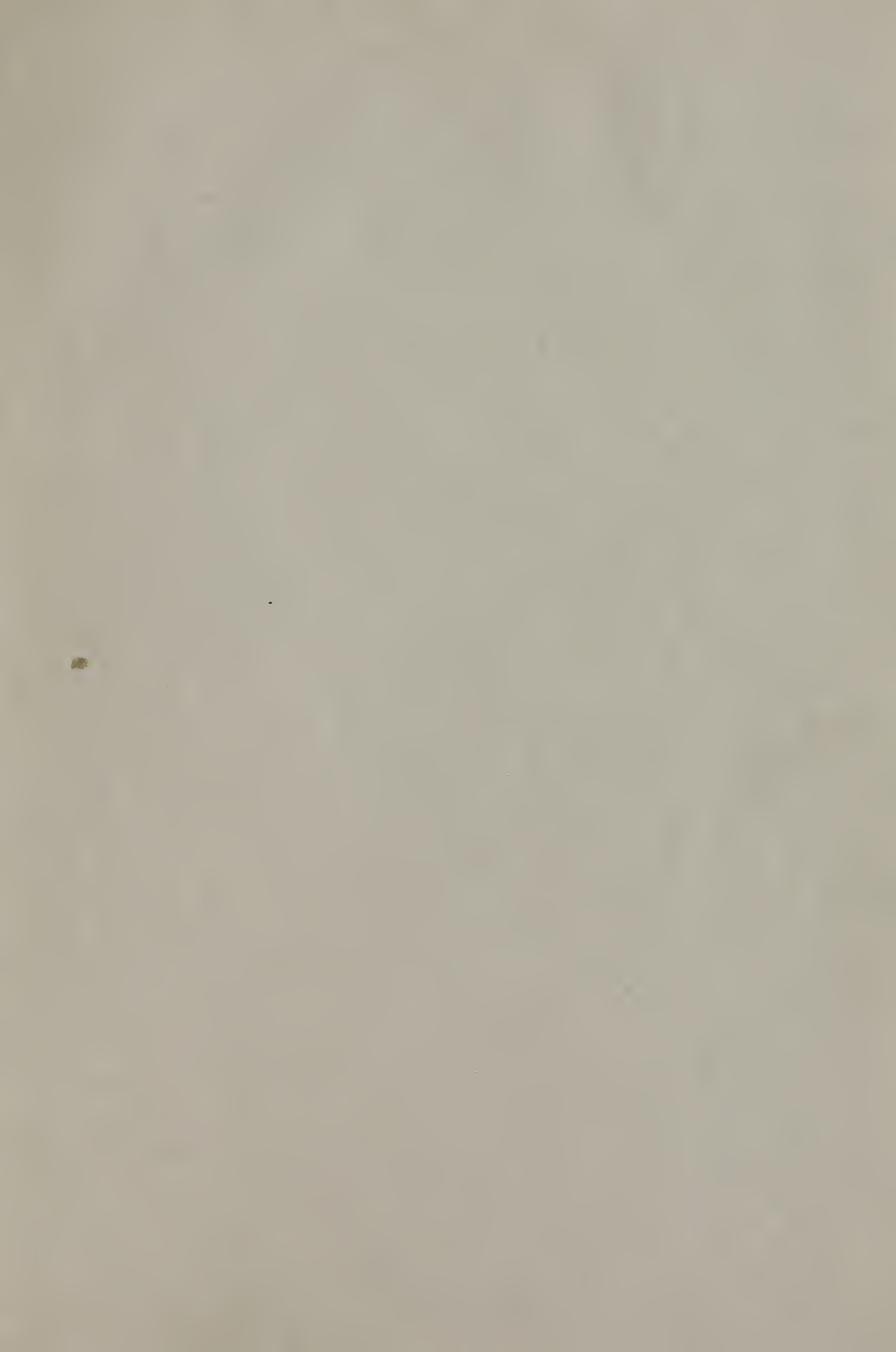
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